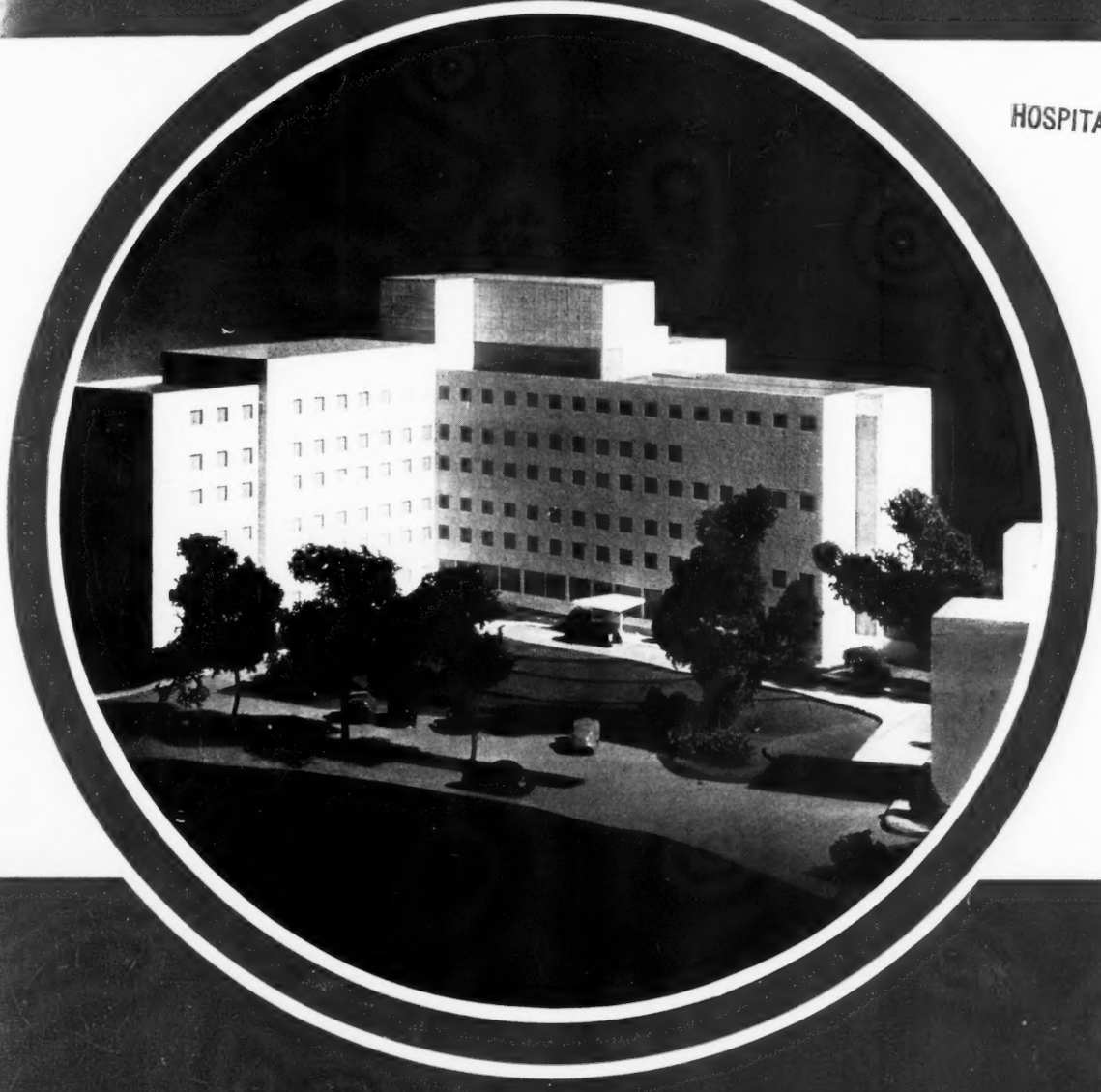
November
VOLUME 69
NUMBER 5
1947

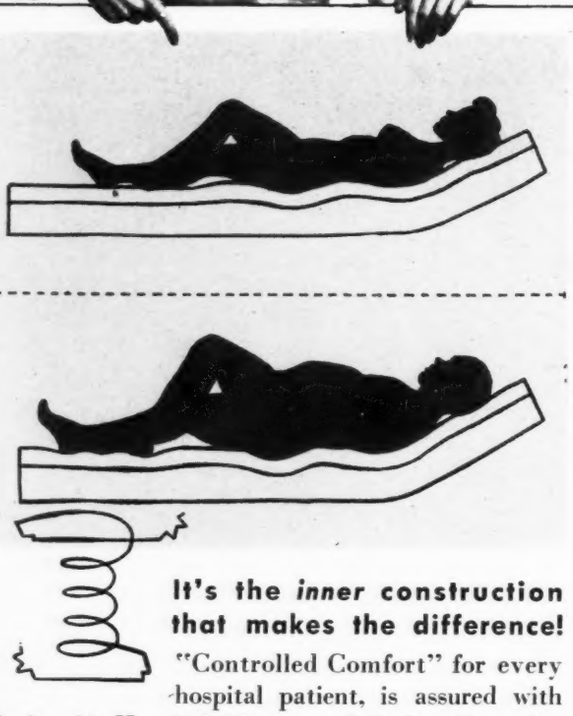
- *...nning a New Hospital for Greenwich, Conn.*
- *S...ritual Factors in the Care of the Sick*
- *L...islation and Problem Drinking*



the Modern Hospital

SPRING-AIR Controlled Comfort

..Proved through Use IN OVER 2,000 HOSPITALS



It's the *inner* construction that makes the difference!

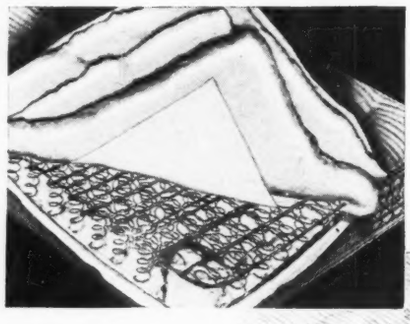
"Controlled Comfort" for every hospital patient, is assured with Spring-Air Hospital Mattresses! Spring-Air spring construction automatically adjusts to the weight of the patient . . . conforms to, and supports, contours of the body—thereby aiding *every patient*, regardless of weight, in getting the best possible comfort and rest.

THOUSANDS OF SPRING-AIR MATTRESSES HAVE ALREADY GIVEN COMFORTABLE SERVICE FOR 10, 12, 15, EVEN 18 YEARS

● Hospital records *prove* the value of Spring-Air Hospital Mattresses, in "Controlled Comfort" . . . durability . . . convenience and ease of handling . . . and economy.

The best evidence of Spring-Air quality, in every detail of design and construction . . . and of the preference which leading hospitals have for Spring-Air Hospital Mattresses . . . is the *satisfaction* and *enthusiasm* of hospital users through the years. (Names of long-term users supplied on request.)

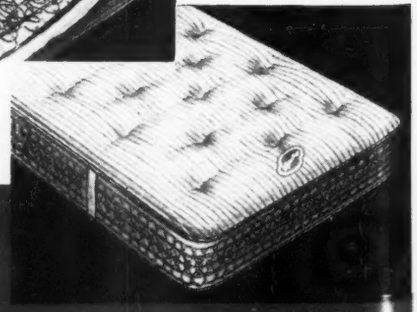
SPRING-AIR COMPANY
DEPT. 1113 • HOLLAND, MICH.



Every Spring-Air is made with the famous Karr innerspring construction, using as many as nine different type coils, each performing its own part in "controlled comfort" . . . assuring individual comfort regardless of the sleeper's weight.

Spring-Air Hospital Mattresses are fully flexible due to their Karr pivot hinge spring construction. Especially suited to use on Gatch-type hospital beds.

Spring Air MATTRESSES HOSPITAL



Examine Spring-Air closely . . . look at the ticking, vents, grips, tailoring. Sit on it, feel it, test it in any way you wish . . . you'll find Spring-Air's fine inside and out! When you select Spring-Air you'll know you chose wisely.

E F F G E E

to the ear or "F.G." to the eye identifies ferrous gluconate, now combined with liver-stomach concentrate to provide 'Lextron F.G.' (Liver-Stomach Concentrate with Ferrous Gluconate and Vitamin B Complex, Lilly).

Clinical investigation reveals that ferrous gluconate has two important advantages over other iron salts:

1. *More efficient utilization of elemental iron.*
2. *Less gastric irritation.*

'Lextron F.G.' is effective in the treatment of both pernicious and secondary anemias. It should be used only under the direction of the physician.

Lilly

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This Month

WE INTRODUCE....

Russell L. Dicks, D.D., is chaplain at Wesley Memorial Hospital, Chicago, and president of the chaplains' section of the American Protestant Hospital Association, which he helped to organize a year ago. He is also a member of the faculties of Garrett Biblical Institute, McCormick Theological Seminary and Chicago Theological Seminary.

Dr. Dicks is a native of Oklahoma and attended Tulsa University and the University of Oklahoma. He took his graduate training at Union Theological Seminary; while he was studying there he was hospitalized several times for treatment of a bone infection. This led to an interest in the psychology of illness and ministry to the sick, which became his life work. In 1933, he went to Massachusetts General Hospital to supervise the clinical training of theological students and ministers. Here he was associated with Richard C. Cabot, M.D., with whom he collaborated in writing "The Art of Ministering to the Sick," which was published in 1936 and has been widely used, quoted and reprinted.

Dr. Dicks came to Chicago in 1938 as chaplain of Presbyterian Hospital. In 1941, he went to Dallas, Tex., as associate pastor of the Highland Park Methodist Church there and assistant professor of theology at Southern Methodist University. During the war, he conducted seminars for chaplains and local clergy in defense areas and lectured for Y.M.C.A.-U.S.O. groups. He returned to Chicago to take up his present work in January 1944. Dr. Dicks has written numerous books, pamphlets and articles dealing with the spiritual aspects of caring for the sick, which is the subject of his paper on page 51 of this issue.

Celia Payton is director of the clinic at Women and Children's Hospital, Chicago. She has been a member of the hospital staff since 1941, with the exception of two years during the war when she served as head of a Red Cross unit at an Army Station Hospital in San Francisco. Mrs. Payton is a graduate of Lewis Institute, Chicago, where she studied sociology and psychology. She took graduate study at the University of Chicago in medical social work, doing case work with patients at Billings, Michael Reese, Cook County and other Chicago hospitals. For a short time after the war, Mrs. Payton was on the staff of the Chicago Welfare Department as a senior medical worker. Her article in this issue of The Modern Hospital is her first appearance in print.

Dora Goldstine is assistant professor of medical social work at the University of Chicago. A thoroughgoing Chicagoan, Miss Goldstine started attending University of Chicago schools in the third grade and continued there through elementary, secondary and college levels, until she took her master's degree in the school of social service administration in 1931. As an undergraduate she had majored in English, and following graduation she went to work as a manuscript editor for the *Journal of the American Medical Association.* This turned her interest toward medicine and she returned to the university for her graduate work in medical social service. She worked for three years at the Presbyterian Hospital in New York City, then came back to Chicago on the staff of the unemployment relief agency. She has been a member of the faculty at the university since 1935.

Now associate director in charge of public relations and education of the Research Council on Problems of Alcohol, **Joseph Hirsh** has spent most of his professional life in public health administration and educational work, serving on the staffs of health foundations, the U. S. Public Health Service, U. S. Office of Education and in the planning section of the Office of War Information. As a major in the sanitary corps of the army medical department during the war, Mr. Hirsh's assignments included a tour of duty in South and Central America, working on the health projects sponsored by the Office of the Coordinator of Inter-American Affairs; he was also chief of preventive medicine and venereal disease control officer for the 12th Air Force in Italy and at other stations. After the war, he became director of medical administration for Veterans Administration hospitals and clinics in New York State, a position he left to join the battle against alcoholism. His book on the alcohol problem, from which a chapter appears in this issue, is soon to be published by Duell, Sloan and Pearce.

Helen Goodwin, R.N., entered the administrative field through the nursing profession. A graduate of Peter Bent Brigham Hospital, Boston, Miss Goodwin was a head nurse, night supervisor, instructor and executive assistant to the superintendent there before going to the Rumford Community Hospital, Rumford, Me., as superintendent of the school of nursing and of the hospital, a position she has held since 1935. She has served terms as secretary and president of the State League of Nursing Education and was appointed by the governor of Maine to the State Board of Registration of Nurses, on which she served for seven years. She is now in her second term as president of the Business and Professional Women's Club in her community and also serves as Sunday school superintendent in the Baptist Church.

THE ROVING REPORTER

V.A. Takes to Gardening

Civilian sanatoriums may wish to take a leaf from the V.A. book. At Louisville, Ky., bed patients with tuberculosis are showing great interest in gardening.

V.A.'s special services and occupational therapy section got together with the Red Cross to provide seedling boxes small enough to fit on bedside tables.

The boxes arrived and the same day an experienced florist visited the boys to give them their first lesson in gardening. The florist was an ambulatory patient in the hospital.

After the would-be gardeners learned the fundamentals of preparing the soil and caring for plants, they were shown an assortment of greenhouse flowers from which to make selections for their own experiments.

The chief of occupational therapy at the Louisville V.A. hospital thinks the gardening project is one of the best yet in relieving the monotony of day after day of bed rest.

Dunkirk Helps Dunkerque

From Dunkirk to Dunkerque went money, clothing, equipment, food and other articles in last Thanksgiving's big celebration at Dunkirk, N. Y. This Thanksgiving the infants in Pouponniere, a baby hospital in Dunkerque, France, and the nurses who care for them will be cozy and warm, for a piece of equipment donated by the U. S. Radiator Corporation last fall was a central heating system complete with radiators and a boiler. American Aid to France, Inc., decided, after surveying the needs of Dunkerque, that the babies' hospital deserved this modern heating method in place of its tubular sheet iron stoves. It is soon to be installed.

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Chief interest in the North American portion of the exhibit is the scale model of Michael Reese, present and future. Museum officials are said to have stated that this is the finest scale model ever presented at the museum for exhibit. It was made under the direction of Reginald Isaacs, John Black and George Kolinsky of the hospital's own planning staff.

New Slant on Cornerstones

Few hospitals are blind to the publicity values of such ceremonies as laying the cornerstone of a new building. In fact, the cornerstone ceremony has been built up into quite an observance, with trustees, women's auxiliary members, medical and nursing staffs dancing at-

Protect your DOCTORS NURSES PATIENTS

from the hazards of explosive anesthetics by installing

CROUSE-HINDS *Explosion-Proof*

*CONDULET Electrical Equipment in your operating rooms

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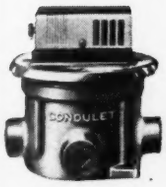
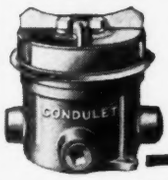
Electrical installations and equipment should conform to the requirements of Class I, Group C locations as set forth in Article 500 of the 1947 National Electrical Code (atmospheres containing ethyl ether vapors). Equipment which is approved only for Group D (atmospheres containing gasoline or similar vapors and gases) is not suitable for Group C locations.

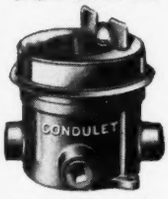
Crouse-Hinds explosion-proof CONDULET electrical hospital equipment meets the Code requirements for both Class I, Group C and Group D locations.



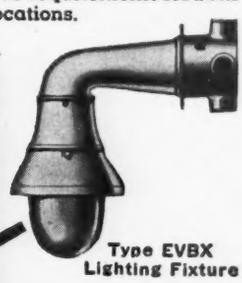
Thermostat



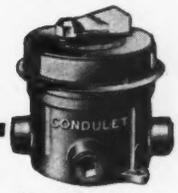
Hand or Elbow Triple Switches



Foot Operated Switch (Standard or Nurses' Call)



Type EVBX Lighting Fixture



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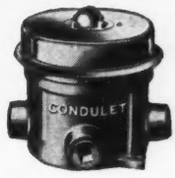
Plug Receptacle

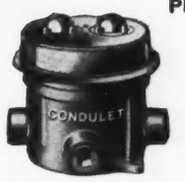
Type EHS3 CONDULET

Blank Cover

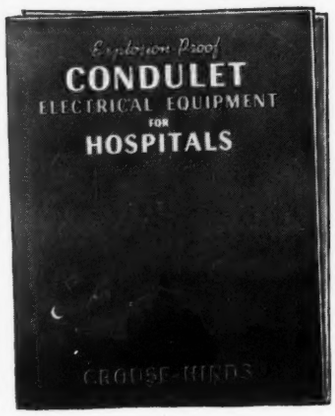
Hand or Elbow Duplex Switches



One Signal Light



Two Signal Lights



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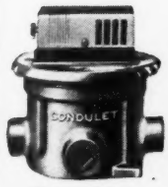

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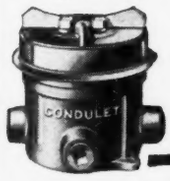

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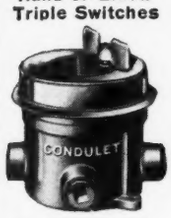

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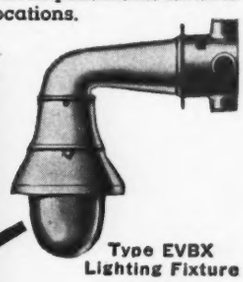
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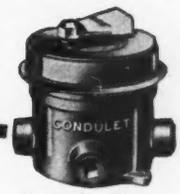

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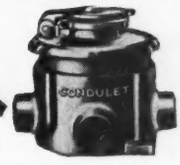

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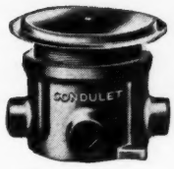

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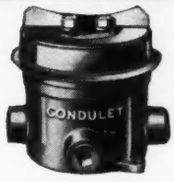

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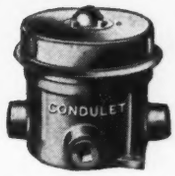

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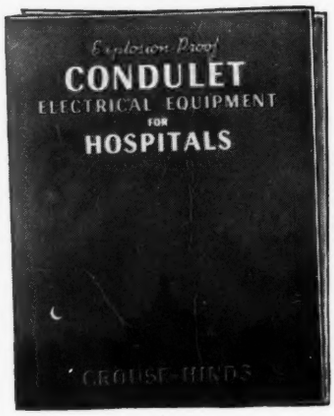
Two Signal Lights



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tendance and, perhaps, with insurance against rain. Not many representatives of the General Public show up but they read all about it in the papers and feel public pride in the enterprise.

A note of originality in the more or less routine cornerstone ceremony bobs up at South Bend, Ind., where the University of Notre Dame recently laid the formal stone of its new Laboratory for Germ-Free Life.

Notre Dame expects this building to last 200 years and on that theory it placed in the stone's strong box biological specimens that may be analyzed for viability, potency or comparative changes with similar specimens in the 22d century.

The new Notre Dame laboratories are to be used for the production of germ-free animals in large quantities for use in medical problems and as a basis for bacteriologic research.

Into the box went samples of penicillin, streptomycin and sulfa drugs; samples of soil, rain and lake water; types of A and B human blood; every known vitamin; animal tissues from germ-free and other animals; certain plant seeds and specimens of diseased plant tissue, and other natural forms.

Bacteria cultures were frozen and dried out by vacuum for preservation. The copper box housing the specimens was filled with nitrogen and sealed with solder. Eventually it is expected to yield information of great interest to scientists.

Chest X-Rays Cost 90 Cents

A community service many metropolitan hospitals could envy is being given by the 60 bed Door County Memorial Hospital at Sturgeon Bay, Wis. For six months the hospital has been offering the public low cost chest x-rays in an effort to discover and eliminate all tuberculosis from the community.

Six days a week, with somewhat shorter hours on Saturdays, the hospital has been open for the work. The examination takes less than ten minutes and costs the person 90 cents.

The state board of health lent the hospital an x-ray machine for six months. The films are 4 by 5 inches and two exposures of each chest are made. Interpretations are made by Dr. Mary Fetter, the hospital's roentgenologist.

When the machine first arrived last April the hospital's first task was to examine the chests of all employes. Immediately thereafter, it began to make routine examinations of all persons admitted to the hospital.

Franklin D. Carr is the superintendent.

Aujour d'hui

Some society folk—we just read about them in a gossip column—have advanced the cause of modern architecture by building two ultramodern houses, one in some American retreat and another in the south of France. In deference to their own modernity the owners call both houses "Aujour d'hui."

The same name could be given to the 42d and best report of Middlesex Hospital, Middletown, Conn., although its own title, "A Report to the People of Middlesex County," is actually better.

For a high class professional job of reporting to its public, no corporation report to its stockholders could present a better thought out appeal to the reader. The interlarding of the copy with enormous action pictures, many of them intriguing angle shots, makes it look more like the catalog of a photography salon; the copy on the opposing pages is printed in quite large type with widely spaced lines and is simple and telling.

Nor is it any accident that 12 pages of the 64 page booklet are assigned to volunteer service. Each committee has its own page or half page and in this section are several photo-chart combinations; these are statistical graphs superimposed in color over an appropriate area of the photograph. The second color used throughout the book is a process red.

READER OPINION

Aw, Shucks!

Sirs:

CONGRATULATIONS CONVENTION DIGEST REFLECTS SMART SPEEDY AND HELPFUL WORK OF MODERN HOSPITAL STAFF.

Basil C. MacLean, M.D.
Rochester, N. Y.

Sirs:

Several Indiana hospital administrators received their copies Saturday morning and called me immediately, stating that The MODERN HOSPITAL was certainly to be congratulated on its rapid-fire action in presenting this post-convention material.

Albert G. Hahn
Evansville, Ind.

Sirs:

For those of us who were compelled by circumstances to miss the convention it was a pleasant surprise to receive the Digest, and especially to have it arrive so promptly. You are to be congratulated on this up-to-date type of reporting.

Jessie P. Allen
Kingston, N. Y.

Sirs:

The Convention Digest is again tops. It's the nicest present any bone tired conventioneer can have: Not to have to report to anyone—just hand them the Digest.

Ronald Yaw
Grand Rapids, Mich.

Sirs:

Congratulations on the Digest. It almost beat us home!

Sister M. Patricia, O.S.B.
Duluth, Minn.

Sirs:

The speed with which you got out the Digest was matched only by the topnotch reporting of the convention itself. A most important contribution to hospitals.

J. Harold Johnston
Trenton, N. J.

Sirs:

You are certainly to be complimented on the excellent Digest which you had in the hospitals practically before the last gun had been fired in St. Louis.

W. L. Wilson Jr.
Danville, Pa.

Sirs:

We feel that all our board members should read this publication.

Ralph F. Lindberg
Detroit

Sirs:

I wish to congratulate you . . . outstanding job . . . you scooped the boys. . . .

R. O. Daughety
Houston, Tex.

Sirs:

. . . You have done a fine service to hospital administrators. . . .

Omer B. Maphis
Kenosha, Wis.

Sirs:

Mine was in Monday morning's mail. . . . It was waiting for many on their return to their desks. . . . A grand job. . . .

Robert G. Whitton
Alexandria, Va.

Sirs:

. . . A swell job. . . .

Graham F. Stephens
St. Louis

Sirs:

. . . Authentic and easy reading. . . .

L. E. Richwagen
Burlington, Vt.

Sirs:

. . . An excellent review. . . . I'm forwarding a copy to the president of our board of directors.

Frank C. Sutton, M.D.
Rochester, N. Y.

Sirs:

I should like to take this opportunity to compliment you on your publication, "The Convention Digest." To receive this so soon after the convention is indeed an accomplishment and I should like to be one of the many who will be commenting on your good work.

J. W. Gavers
Springfield, Mass.

Sirs:

I was astonished to receive The MODERN HOSPITAL booklet describing convention scenes only three days after returning from St. Louis. A fine job as well as a fast one. Congratulations!

Harold K. Wright
Sioux City, Ia.

SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.

Standardization Does Pay

Question: Does it pay the small hospital to establish standards for all kinds of equipment and supplies, and to set up regular purchasing procedures for all departments?—R.M., Ill.

ANSWER: In small hospitals buying is often placed in the hands of a secretary or a clerk. Prior to 1941, recognition of the importance of having and maintaining good purchasing standards in all hospitals was notable mainly for its absence. The war years, because of shortages, provided an impetus and underlined the need to establish better hospital buying standards and to further the study of simplification with all its attendant potential savings.

Since most hospitals are at least partially maintained by contributions and operate on a nonprofit basis, we in the hospital field, who have nothing to sell but, instead, help cure the ills of the sick, must make every conceivable saving possible by buying only those supplies and equipment that can give us the greatest value per dollar spent. The development of simplification and standardization within every hospital, as well as for hospitals generally, means increased economies and savings for hospitals and, I believe, increased economies for manufacturers.

The growing trend toward the establishment of sound purchasing standards is still a new movement, but it is one which will grow until every hospital in the country adopts and establishes sound purchasing practices.—CHARLES O. AUSLANDER.

Employes Have Guests, Too

Question: How many guests should employes be allowed to have during a month?—M.W.L., Ga.

ANSWER: I cannot believe that any limit is necessary on the number of guests an employe should be allowed during a month. The number of employes who will abuse the privilege of having guests is so small that the few who do can best be handled on an individual basis. Restrictive rules of this nature are frequently a source of irritation.—WILLIAM J. DONNELLY.

Small Hospital's Contribution

Question: How can the small hospital, particularly the small rural hospital, contribute to the educational system for nurses?—M.W., Iowa.

ANSWER: A small rural hospital may provide a valuable affiliation for the student nurse from a large nursing school, provided the nursing staff of the rural hospital is qualified to guide students and the hospital recognizes its place as a community health agency, as well as a place to care for the sick.—PEARL MCIVER.

Disposing of Garbage

Question: Will you please give me information about the various methods of disposal of hospital garbage?—L.G.P., England.

ANSWER: We know of only three methods of disposing of garbage in a hospital. One of them is to collect the garbage in cans at the source and move these cans to a central incinerator where the material is passed to the incinerator (preferably from overhead) after having been raked to recover any instruments, silver or other valuable items. The cans are then washed in a special can washer with plenty of hot water and steam and then returned whence they came.

Garbage is also handled in many hospitals in this country via a chute type of incinerator. Some hospitals use a chute without the incinerator, but that is generally frowned on by the sanitary authorities. The chute incinerator, however, is generally approved, as the garbage or waste drops down what is really a smoke flue directly onto the incinerator bed below. At intervals, gas or coal or some other heating medium is used to ignite the mass in the incinerator. In a large hospital this presents difficulties because of the volume of kitchen waste, the size of the incinerator that would be necessary and the probability that the incinerator would have to work much of the day, so that it would be difficult to empty the kitchen waste into it.

These two methods, the chute incinerator and the central incinerator, are sometimes combined—the chute incinerator to dispose not only of garbage but of all waste on floors; the central incinerator, to dispose of garbage and waste of all kinds from the big producing areas, such as the kitchen.—CARL A. ERIKSON.

The Painting Program

Question: How can we keep the census up and still continue a painting program?—V.M.W., Mass.

ANSWER: This is a problem that bothers everyone today and is a hard one to solve. If you have your own painters, then it is not so difficult as they can be called in to do a room on short notice.

This is the way I work our painting program, along with the housekeeper, admitting clerk and the nursing department, in order to keep up with the demand for clean rooms: A schedule is laid out to wash and paint patients' rooms, by taking one room at a time. It is up to the housekeeper and the nursing supervisor to arrange to move furniture and to transfer patients who are able to be moved. As one room is done a patient is transferred from another room into the freshly decorated room as soon as it is possible, which should not be more than three hours after the painters finish.

The time between is used by the painters to wash and paint, if necessary, the corridors, duty rooms, janitor closets, nursing office, kitchen and all other public rooms that are on the same floor. This eliminates a lot of moving around, but if a room is free on another floor, because a patient is going home, then that room should be done before another patient is admitted. An accurate list of the rooms done, including a notation as to whether they were washed or painted, or both, and the date, should be kept at all times so that rooms can be done on a schedule. By this method there need be only one room out at a time, which should not interfere too much with the patient occupancy of the hospital.

It is important that the housekeeper, nursing supervisor, admitting clerk and whoever is in charge of the painters work closely together so that all can cooperate in carrying out such a program.—LELAND J. MAMER.

Educating the Staff

Question: How can staff education for both the medical staff and nursing personnel be stimulated in the small hospital?—N.J.P., Ill.

ANSWER: By organization and encouragement by the administration and board of attendance at meetings; also by the importation of outstanding men in their respective fields for lectures and short courses.—ROGER W. DEBUSK, M.D.

LOOKING FORWARD

When Sorrow Strikes

ONE of the hardest tasks the administrator has is the interview with relatives of a patient who has died in the hospital. Many administrators avoid this meeting entirely unless it is plainly called for by circumstances or requested by the family. It is arguable, at least, that the attending physician should take full responsibility for dealing with the bereaved family and that the hospital administrator does not belong in the picture at all. Moreover, it is a fact that many administrators are not emotionally equal to this difficult situation and will only add to, instead of easing, the family's burden.

But it is also a fact that some physicians need and would welcome help on these trying occasions and that many administrators can render a service for which the family will be everlastingly grateful. Certainly, however, the administrator who approaches any such meeting with the idea that it is a "public relations opportunity" for the hospital is going to fail miserably of achieving any worth while purpose; at such times, the ear is hypersensitive to phony overtones in the conventional phrases. Instead, the administrator should aim simply and earnestly at being helpful.

It is not necessary, for example, to review the case or to offer any information or opinion about the care of the patient. Members of the family will ask questions if they want to know anything along these lines; it is a mistake for the administrator to feel that he must volunteer an explanation of the patient's death. Usually, it is also a mistake for him to offer philosophic or spiritual consolation. This is the priest's or the minister's bailiwick. Unless the administrator knows the family intimately, there is little chance that he can do any good, and he may easily say something inappropriate if he attempts to be lofty.

On the other hand, there are many practical things he can do, in addition to offering sympathy on behalf of the hospital staff. Immediately following the patient's death, for example, most families would deeply appreciate the privacy of an office and the use of a telephone, and possibly the services of a stenographer, to send a few critical messages. If no extra office is available, the administrator should be able to adjust his schedule so that his own office is free for a short period, at least. Of course, hospital routines cannot be completely turned over every time a death occurs. Few families will abuse this courtesy, however, and all will be grateful.

It costs little in time and trouble to serve coffee or tea during these critical moments, yet everyone who has lived through such an experience, and most adults have, knows how much this gesture helps. Taking the lead from the family, the thoughtful administrator may find other opportunities to be useful. He may discuss the necropsy arrangements or offer to inform the press, or give the family advice about dealing with undertakers. Unaffectedly and unobtrusively, he will help out in any way that he can. But unless he has the character and emotional stability to take the situation calmly, so that he will radiate composure, and not tension, he should not try to do anything. To serve effectively on these occasions is not simply another task for the ordinary administrator; it is rather the rare privilege of the true humanitarian.

Backstep

POSSIBLY in response to prodding by the radiologists, whose chip is never very far out of sight, the board of trustees of the American Medical Association is sending hospital administrators and chiefs of staff copies of the recent A.M.A. resolution opposing "encroachment by hospitals and other organizations on the private practice of medicine" and recommending that "all fees for medical services be set by and collected by or for doctors of medicine rendering this service."

This resolution is out of tune with the whole modern effort toward integration of medical services in an economic as well as professional sense. The little band of medical irreconcilables which has forced this action may yet succeed in wrecking the ship while arguing about the purser's methods. Under the system now plainly advocated by the A.M.A., most hospital patients would get at least four bills—one each from the hospital, the attending physician, the radiologist and the pathologist. This is not to mention the anesthesiologist, who would send still another bill, and possible clinical consultants, with theirs.

The uproar that would result if people had to pay four or five bills for hospitalized medical care can readily

be pictured by anyone who is familiar with the public attitude toward today's medical bills, which are regarded by many as unnecessarily complicated already. Nothing the profession could do would give greater impetus to the movement toward compulsory health insurance, which feeds on dissatisfaction with existing methods.

Fortunately, the A.M.A. recommendation is not likely to become the common procedure. Realistic doctors now practicing in hospitals know that wild confusion would follow any attempt to burden the patient with such a round robin of doctors' bills. "We'd never get paid anyhow," one radiologist said, commenting on the fiscal aspects of the proposal. "Instead of losing 1 per cent or less on hospital collections, we could expect a 10 per cent shrinkage, at least, on our billings to angry, suspicious or bewildered patients."

With its emphasis on fees and billing methods, however, the resolution does an injustice to a profession most of whose members are more concerned with the patient's welfare. It is the standard of professional service, and not the method of compensation, that the thoughtful members of these specialties hold most dear. When the hospital provides an adequate workshop in terms of equipment and personnel, a staff organization assuring the radiologist or pathologist of his proper place at the clinician's right hand and at the teaching table, and freedom to express himself in professional councils and conferences, there can be no real "encroachment on the practice of medicine," whether the specialist is paid in fees, commissions, salary or tokens.

Nobody will deny that these physicians, like their colleagues in other specialties, are entitled to adequate financial rewards. The matter of money is important, of course, but it is another matter altogether. As most doctors are proud to acknowledge, professional integrity rests on a sounder base.

No Burlesque at the Ballet

EVERYBODY at the St. Louis convention enjoyed Kay Kyser, the manic movie character who thumped the tub for better hospitals. The Kyser talks were entertaining and his enthusiasm for the hospital cause was engagingly sincere. Obviously, Kyser is a generous, public spirited citizen who has a lot to contribute.

In a way, however, Kyser's appearances on the St. Louis program were disappointing and disturbing. He was expected to discuss methods of organizing public support for hospital projects, the phase of health work whose technics are familiar to him and in which he has scored outstanding successes. Yet actually he devoted only a few minutes to these public relations aspects of the hospital field. The greater part of his time was spent reviewing problems of hospital planning and operation, subjects with which Kyser is extraordinarily conversant for a layman but which he is scarcely qualified to discuss in front of an audience of hospital administrators, consultants and architects. His talks would have been just the thing for a community mass meeting, perhaps, but they seemed obvious and repetitious to many in his hospital audiences. For the most part, of course, he was underlining the point that only well planned, efficiently run hospitals deserve and can expect to command a large measure of public support. This is an important, fundamental truth, but hardly one that needs to be repeated for nearly two hours in hospital meetings today.

The most disturbing thing about the Kyser performances, however, has to do with the propriety of scheduling this kind of speaker at a presumably professional assembly. No sensible person objects to humor in a serious speech; often, as a matter of fact, it helps to make a point clear or give impact to an idea. On such occasions, however, there are limits to the type and amount of humor that should be injected. Many people felt that Kyser exceeded these limits, if not those of ordinary good taste, when he went into his girdle-pulling pantomime and when he made leering remarks about those who left the room during his talks.

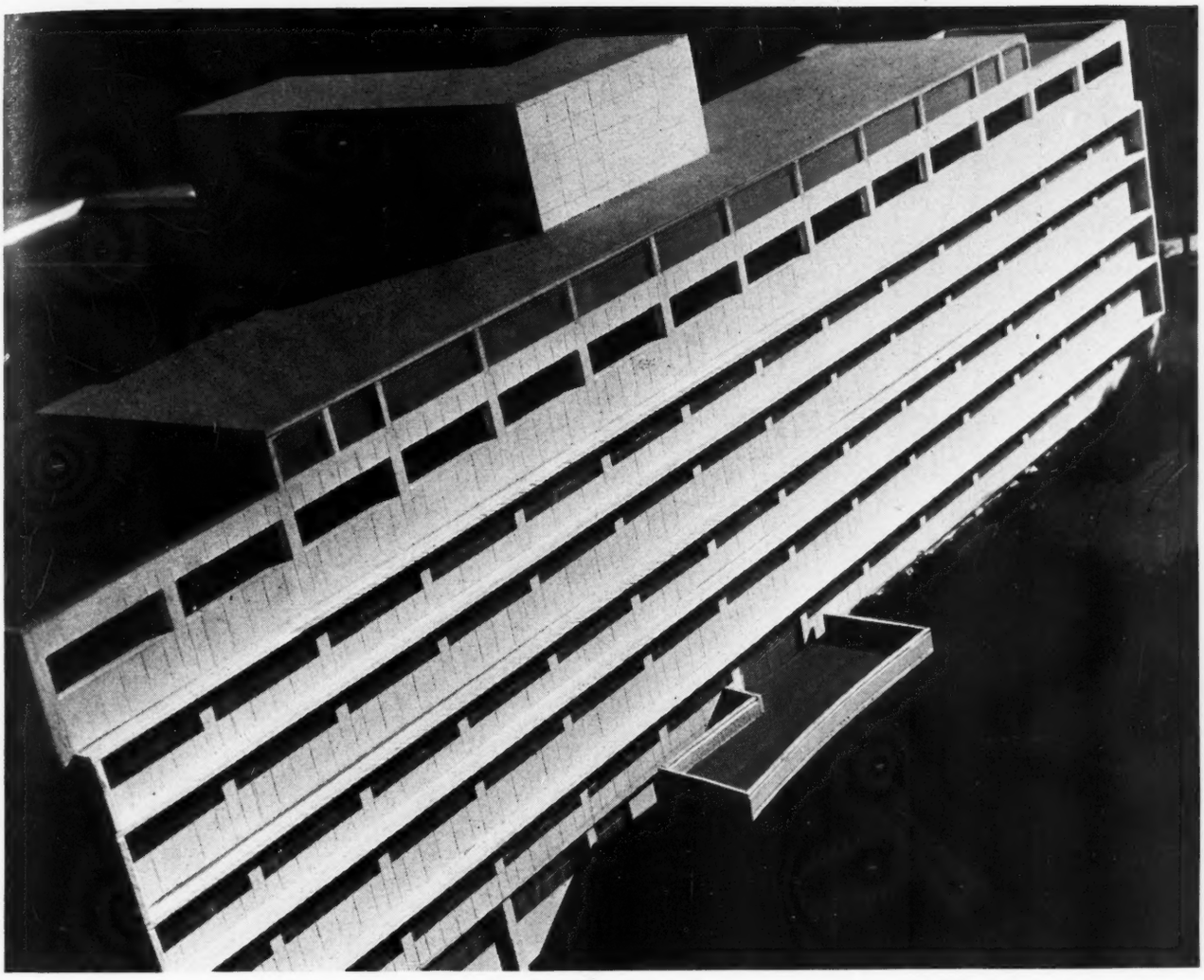
There can be no doubt that Kyser's act went over with most of the hospital crowd. They laughed repeatedly at his jokes, good and bad, and on one occasion several hundred people got up and left when he finished, even though two excellent speakers remained on the program. This kind of behavior reflects little credit on the hospital field. If hospital administrators wish to be regarded as professional people they must act like professional people, not like bobby-soxers. There are no circus acts on the medical programs.

Nice Going!

LAST month, the American Hospital Association, through President Graham Davis, issued a prompt, straightforward statement in support of the national food conservation program. The statement left nobody in doubt about where the association stood in the matter of meatless Tuesdays and eggless Thursdays. It was for them.

This is a wholesome step. In the past, the association has sometimes refrained from taking a positive public stand on national issues affecting hospitals. Yet it is only by taking such an aggressive position that the association can help hospitals become the forceful factor in community life that they should be.

In this case, the immediate response to the association statement was a hard editorial kick in the shins from the *Chicago Tribune*, which doesn't like the food program. This should not discourage association officials from taking a similarly positive stand in the future as the occasion may arise. Public abuse is the badge of office that goes with public responsibility, and the association is strong enough to take it today. By and large, no kick in the shins hurts nearly as much as the ultimate humiliation that results from staying out of a fight to avoid getting kicked.



ARCHITECTS' MODEL OF THE PATIENTS' WING, GREENWICH HOSPITAL, GREENWICH, CONN.

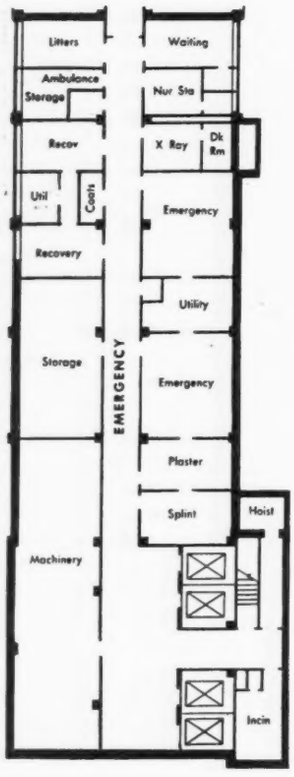
Cooperation Paid Off at Greenwich

ROBERT W. CUTLER
Partner
Skidmore, Owings & Merrill
Architects
New York City

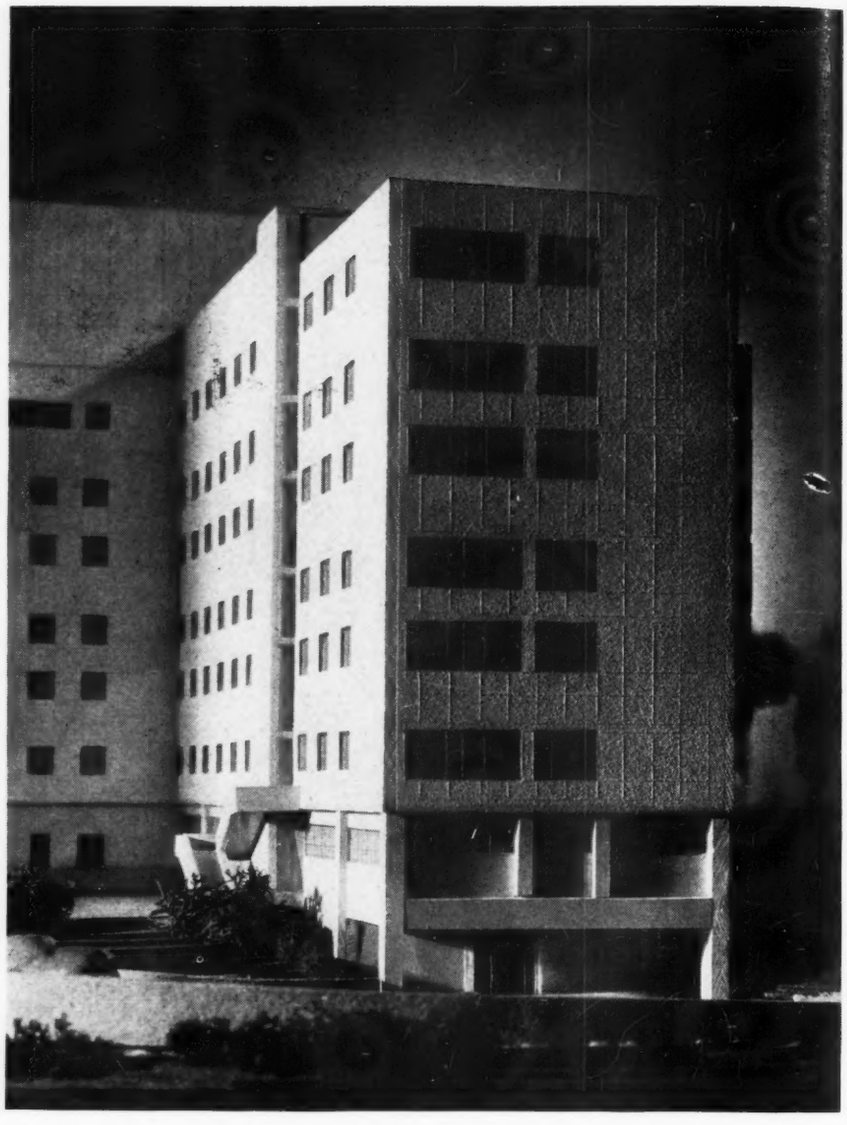
THE year 1940 found Greenwich Hospital, Greenwich, Conn., faced with the problem of serving a population which was twice as large and almost five times as hospital-conscious as it had been 25 years before, when the hospital was built. To make a thorough analysis of the future needs of the community, the directors of the hospital appointed a postwar planning committee and with the aid of a consultant made a survey of administrative policies, physical plant, medical practices and standards.

The findings of this committee were then turned over to a building committee charged with the responsibility of turning those plans into reality. And reality is a good word at this point, for that was the essence of the approach of the building committee to the problem of producing a hospital which not only would meet the needs of a growing population, its possible increasing acceptance of group medicine and the challenge of advances in medical science, but also would embody the principles of design which had long been proposed by hospital staffs.

Probably the most significant aspect of the work during the planning stage was the close cooperation among the various members of the hospital board, the staff and the architects. The first step was the outlining of functional units to be considered. This covered administra-



SUBBASEMENT: The gently rising road from Lake Avenue provides service to the hospital as well as a large parking space for doctors' and personnel cars. The emergency department is located off this service road at the subbasement level. The main elevators connect this function to the hospital services above.



A service wing extends north from the midsection of the patients' pavilion.

tion, engineering, pathology, medicine, surgery, obstetrics, pediatrics and other facilities which were to be included in the planning technic.

Each department was analyzed individually in conference with the administrator and staff members. The results were put into blueprint form without regard for architectural shape or form, submitted to the department for consideration and revised until approved by all concerned, including the consultant. Although the architect's concept of the proper size and shape for a hospital was relegated to secondary position we were, nevertheless, successful in achieving our objective of a graphic interpretation of the various units.

Three facts were now at hand: (1) an existing hospital built in 1915; (2) a site comprising some seven acres, and (3) graphic interpretations of the needs of each of the several departments.

Other considerations were deemed important. The town planning committee was consulted to determine the location of the hospital with respect to the ultimate plan of Greenwich; the chief of police was consulted with regard to traffic in and around the area of the hospital; the board requested that the structure be oriented for sunlight, air and view; consideration of the patient's care and welfare was paramount.

Having acquired all basic information necessary to architectural form, the next objective was to piece together the units and fit them properly into a composite plan. This called for continued studies and conferences with the administrator and the consultant. A scheme was developed which provides for a patients' pavilion of two nursing units on each floor, with the long axis running east and west so that patients' rooms face the south and overlook Long Island Sound.

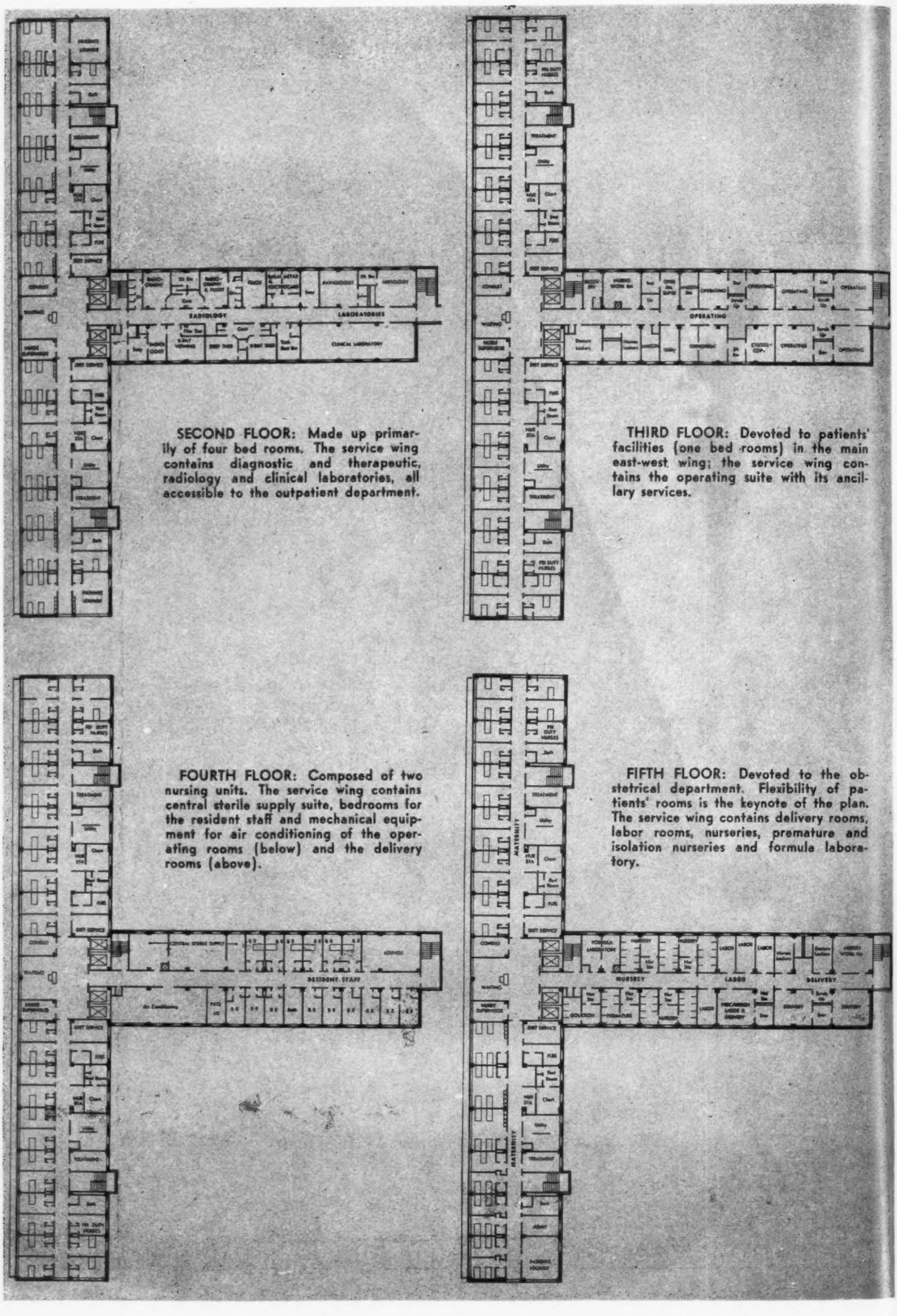
This scheme called for a seven story building, with basement and subbasement, for housing patients and adjunct services. The service wing with operating suites, laboratories and similar facilities extends north from the midsection of this patients' pavilion and joins the outpatient department of the existing structure at basement, first and second floor levels. It is proposed to enlarge this outpatient department and make available to it the ancillary facilities which will also be housed there. Planned in the first instance

BASEMENT: A close relationship has been achieved between the receiving department, the general stores and kitchen facilities at the basement level. Other services provided in this area are the morgue, locker rooms for personnel and housekeeping facilities. The pharmacy, the only department having its own storage facilities, is adjacent to the receiving platform and connected by stairs to the outpatient department above.

FIRST FLOOR: Contains the main entrance lobby with the admitting suite, medical and record library, examining and consultation room, waiting room and business office grouped around it. Administrative offices and a conference board room occupy the remainder of the first floor level. The easterly wing of the "T" contains the pediatrics department. The service shop has been placed opposite the elevators of the first floor and will have an outdoor terrace overlooking the lawns to the south of the hospital.

This area is devoted to parking and loading space.

The patients' pavilion, showing large glass areas.



SECOND FLOOR: Made up primarily of four bed rooms. The service wing contains diagnostic and therapeutic, radiology and clinical laboratories, all accessible to the outpatient department.

THIRD FLOOR: Devoted to patients' facilities (one bed rooms) in the main east-west wing; the service wing contains the operating suite with its ancillary services.

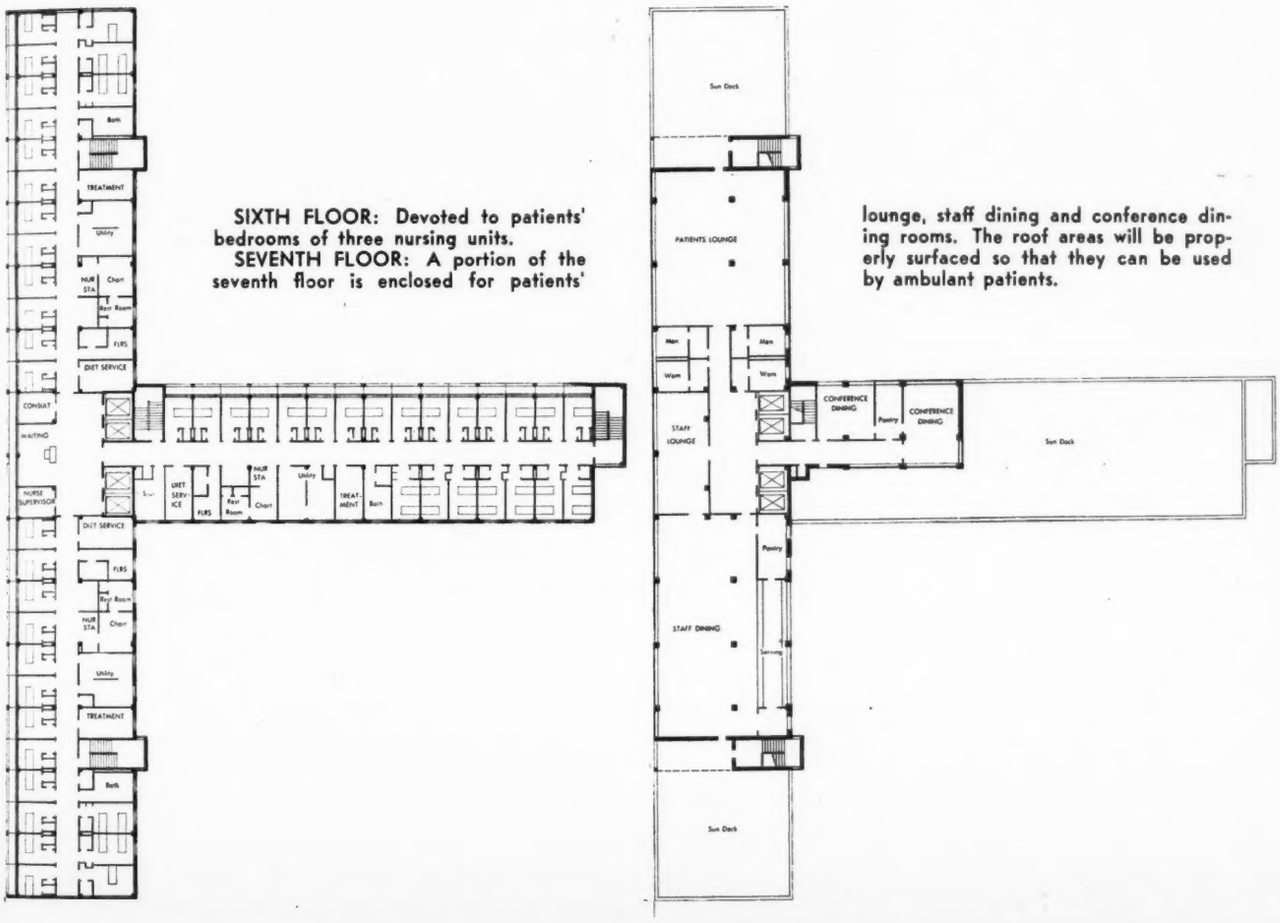
FOURTH FLOOR: Composed of two nursing units. The service wing contains central sterile supply suite, bedrooms for the resident staff and mechanical equipment for air conditioning of the operating rooms (below) and the delivery rooms (above).

FIFTH FLOOR: Devoted to the obstetrical department. Flexibility of patients' rooms is the keynote of the plan. The service wing contains delivery rooms, labor rooms, nurseries, premature and isolation nurseries and formula laboratory.

for 220 beds, the east and west patient wings can be extended to a total of 300 beds. The ancillary services throughout have been planned for the ultimate bed capacity.

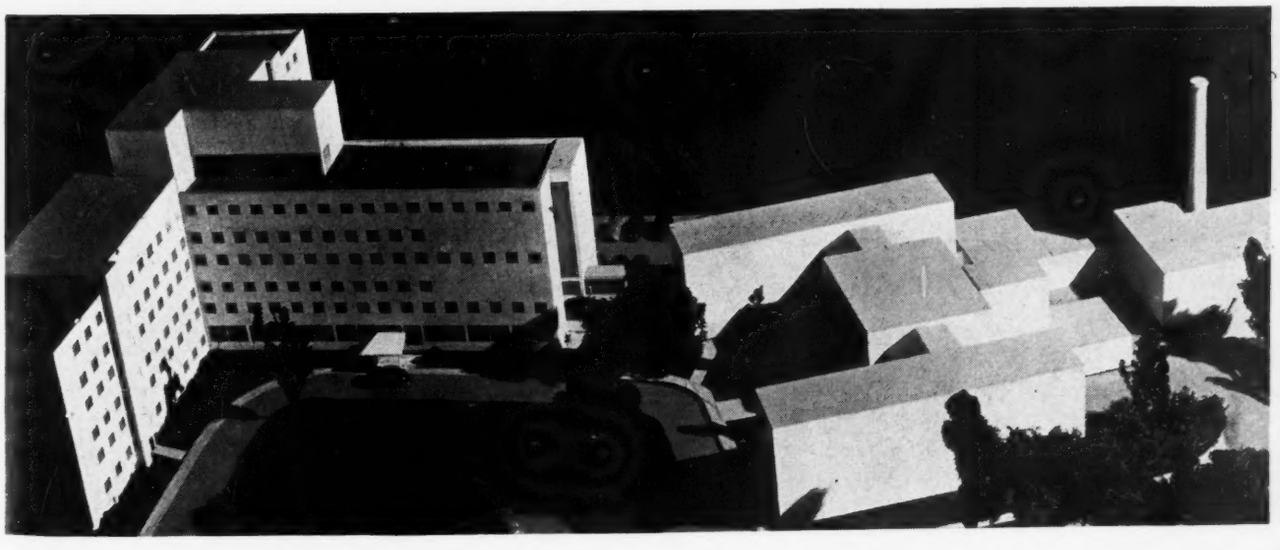
The large glass areas on the south side of the patients' pavilion are protected by sunshades which are not only a form of architectural expression but a functional design as well, since they afford protection from the high rays of the hot summer sun yet admit the welcome low rays of the winter sun into patients' bedrooms. Maximum use was made of the sloping contours in the plan of the basement and subbasement to ensure natural light and air, as well as access to the street.

Nursing units were set up on the basis of an economical use of personnel; walking distances are short, subutility rooms are provided at each patient's room. Similar functional emphasis was placed on the location of service facilities, the central sterile supply being placed between the operating and delivery suites and in the center of patient activity. The air conditioning equipment is located between the two areas it serves—operating and delivery suites. A new laundry and power plant built in 1941 at the rear of the present structure has ample capacity for the new hospital



SIXTH FLOOR: Devoted to patients' bedrooms of three nursing units.

SEVENTH FLOOR: A portion of the seventh floor is enclosed for patients' lounge, staff dining and conference dining rooms. The roof areas will be properly surfaced so that they can be used by ambulant patients.



Reimbursement Rears Its Ugly Head:

American College of Radiology Recommends a Contract

MAC F. CAHAL
Secretary
American College of Radiology
Chicago

WHAT is the best financial arrangement for the practice of radiology in hospitals?

Every day this question is asked in one way or another in letters received at the headquarters office of the American College of Radiology from radiologists, hospital administrators, hospital staff committees and others. The recommendations offered by the college and information submitted in response to such inquiries should be of interest to all radiologists and hospitals.

Radiologist Leases Department

The commission on hospital standards of the American College of Radiology recommends, as the most satisfactory type of fiscal arrangement between a radiologist and the average private hospital, a contract under which the radiologist leases the department at a fixed monthly rental. The agreed monthly rental should cover the use of the space occupied by the department of radiology and the equipment therein, or space alone should the radiologist own the equipment.

An alternative arrangement which permits the radiologist to act as an independent practitioner in the hospital has proved satisfactory in a number of hospitals. Under this method, the radiologist renders bills and collects for all private cases in his own department. The hospital collects for all ward and dispensary cases. The radiologist pays all salaries for technicians and assistants in the department. Films, supplies, other operating expenses and a monthly item for amortization of equipment on a ten year basis are charged to "overhead."

At the end of the month these "overhead" expenses are apportioned between the radiologist and the hospital according to the ratio of private to ward cases. Thus, the radiologist retains all income for private cases and the hospital retains all income for ward cases. These gross amounts are reduced by sharing in the expenses of maintaining the department according to the ratio of private to ward cases.

When radiologists are unable to obtain an agreement for a fixed monthly rental or an arrangement under which they operate as an independent practitioner as described, the commission on hospital standards recommends, as the next most desirable arrangement, a contract under which the radiologist leases the hospital department at a rental based upon a percentage of gross receipts.

The actual figures on prevailing fiscal arrangements between radiologists and hospitals throughout the country today are of interest. Approximately 54 per cent of all radiologists practice their profession on a percentage basis in hospitals. About half these are in the legal position of a tenant, paying the hospital a rental. The remainder are in the legal status of an employe, receiving a percentage of gross or net income as compensation. About 9 per cent of all radiologists lease their hospital department at a fixed monthly rental. The remainder, or about 37 per cent, are employed on a straight salary.

Allow 50 per Cent of Gross

Among the percentage agreements, by far the greater proportion allow 50 per cent of the gross collections as remuneration to the professional personnel in the department. Only 19 per cent of all radiologists practicing on a percentage basis in hospitals receive less than 40 per cent of the gross collections of the department. In contrast, 71 per cent receive from 40 to 60 per cent of gross receipts. The remainder, or 10 per cent, receive more than 60 per cent.

Under most such plans the hospital pays the entire expenses of the department from its portion of the gross receipts. In a percentage-rental lease contract, the college recommends that all operating expenses, including salaries and supplies, be paid by the tenant-radiologist.

(*Continued on Page* 50.)

Contract or Salary for Radiologists?

Questionnaire Study Shows Salary Is More Satisfactory

EDWARD BRODSKY
Boston

THIS study was initiated on behalf of a hospital that was seeking an equitable method of reimbursing its radiologist and pathologist. Letters were written to a selected group of 120 hospitals requesting information as to their experience in dealing with this subject. The response to these letters was excellent; 84 replies were received, which represented 70 per cent of the letters sent out.

Although the letter of inquiry merely requested a limited amount of information of a general nature, the administrators who replied generously furnished specific data, including salary ranges, methods of reimbursement and forms of contract. In addition, many offered opinions based on knowledge and study of this problem within their own hospitals and as it exists and is being dealt with in the hospital field as a whole.

Would Favor Hospitals

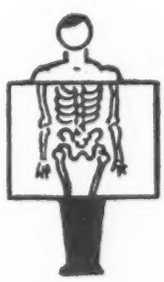
In writing this report I am endeavoring to serve as a reporter of facts garnered from administrators who replied to the questionnaire. It could, therefore, be stated that the information abstracted from these letters would most likely favor the interests of the hospitals above those of the radiologists and pathologists.

Following is a summary of the principal findings as revealed in this survey:

1. Although it is true that the American College of Radiology collects and disseminates information and data to its members relative to modes of reimbursement and provides them with a standard form of contract, the radiologist is a free agent and can voluntarily enter into any form of financial remuneration with the hospital that is mutually acceptable.

2. The hospitals that have established a salary basis of reimbursement with their radiologists and pathologists have the most satisfactory arrangement. The specialist works full time and is available for consultation and the service is highly satisfactory from the standpoint of the patients, staff doctors and the hospital.

3. The teaching hospitals and larger general hospitals attract specialists who are willing to accept the salary basis of reimbursement at a rate that is not excessive. The smaller hospitals, conversely, engage part time specialists on a commission or profit sharing arrangement that reimburses the specialist for the time he puts in, at a rate that is far above the scale of the full time men. In fact, the commissions received in some instances from the smaller hospitals for part time service reached a sum greater than that received by the full time specialists.



4. It was interesting to note that there was no standard method of profit sharing or commission basis of reimbursement among the reporting hospitals. In other words, other than those specialists engaged on a straight salary basis, each hospital negotiated individually in accordance with local conditions and precedent.

Business Acumen Lacking

5. It was also evident that the administrators did not display sufficient business acumen when establishing the profit sharing arrangement with the specialists. To wit: should the profit sharing arrangement be based on a percentage of gross earnings, net earnings or cash collections? A lack of perception of the elements involved in establishing the formula was evident, as many permissible overhead and indirect expenses were not deducted before profit sharing. Failure to include Blue Cross adjustments, free work and allowances before arriving at a net earning figure was evident in many instances.

6. The inadequate accounting and bookkeeping procedures of many hospitals do not lend themselves to a proper method of computing the in-

(*Continued on Page* 50.)

BRODSKY: SALARY IS MORE SATISFACTORY

(*Continued From Page* 49.)

direct and many of the direct expenses that should be applied before profit distribution. If hospitals would adhere to the principles of accounting as recommended by the American Hospital Association and revise their systems accordingly, a proper basis for determining costs would be available and the hospital would thereby be entitled to a more favorable percentage of the net receipts.

7. Consideration must be given to the classes of patients served by the hospital before establishing the bases for profit sharing inasmuch as the income varies from these sources. That is, ward cases may pay lower rates or nothing at all for diagnostic services and ambulatory patient rates may be in excess of or comparable to those of private patients.

8. X-ray and laboratory rates and charges must be reviewed periodically. These rates must be consistent with costs and not priced beyond the patients' means.

9. Those specialists who maintain a practice in an outside office undoubtedly are in competition with the hospitals they serve when the office is maintained in the same community. This, also, is an element to be considered.

10. Profit sharing or commission basis contracts should be drawn up for a maximum of one year. These contracts can be renegotiated on the basis of the previous year's experience or, preferably, weighted on the experience of the preceding three years. The specialist's income is thereby stabilized, "peaks and lows" are eliminated and a more harmonious relationship can be hoped for in the future.

11. It is recognized that many hospitals cannot discard a profit sharing arrangement that has been in effect for many years and it would not be desirable to disturb an accepted form of relationship between the hospital and specialist. On the other hand, objections should not be raised to amending or modifying the contract in favor of the hospital if it is indicated that the specialist's percentage of the income is to the distinct disadvantage of or creates a loss for the hospital.

12. The most equitable form of profit sharing, when the specialist is engaged on a part time basis, would be a fixed salary for a specified number of hours daily or weekly. If the specialist requires an incentive arrangement, then the additional bonus, granted annually, can be included. This bonus will be a percentage of the net profit after both the specialist and the hospital receive a specified guarantee from the net operating income.

13. A practical arrangement for small hospitals within a single community would be to engage a specialist under a single contract to serve two or more hospitals. The hospitals could share his salary on the basis of the ratio of beds or patient days of the individual hospitals to the total beds or days of the group.

14. In some communities, the availability of qualified specialists is a factor that must be ruled upon because the supply and demand for qualified men may have a bearing on the amount of salary that the specialist may require.

CAHAL: RECOMMENDS A CONTRACT

(*Continued From Page* 48.)

There have been frequent statements in the hospital literature of late to the effect that most radiologists prefer to work on a straight salary. It is also alleged that efforts to preserve the practice of radiology in hospitals on a fee for service basis and to retain the position of the radiologist as an independent practitioner of medicine represent the views of only a "small and vocal minority" in radiology.

Anyone familiar with the facts will recognize the falsity of these statements. Principles of the American College of Radiology pertaining to the relationship between radiologists and hospitals have been endorsed by the entire membership and obviously represent the views of the great majority of practicing radiologists. These principles have consistently urged that radiologists be permitted to practice their specialty in the hospital as independent practitioners in the same manner as do other members of the staff.

With due regard for certain factors peculiar to the specialty of radiology in hospital practice, the fiscal arrangements outlined have been recommended. They permit the hospital to be reimbursed from the fees earned by the radiological staff for its entire costs in maintaining the x-ray department with a fair return on its investment in space and equipment. They are consistent with the principles adopted by the Council on Medical Education and Hospitals of the American Medical Association in its hospital approval program.

The standards promulgated by the A.M.A. include the provision that "it shall not be the policy of the hospital to make a profit from the department of radiology." The merit of this principle is recognized by leading hospital administrators and medical men alike.

Each year additional hospitals, after negotiations between the staff radiologist, staff committees and the hospital administration, change their existing arrangements to one more consistent with the principles advanced by the American College of Radiology. Although no recent study has been made, it seems safe to assume that the number of hospitals employing radiologists upon a straight salary have decreased and that an increased proportion have entered into agreements similar to those described.

This is an encouraging and a healthy trend. It offers promise of advantages for all three parties concerned: the hospital administration, the patient and the radiologist.

Spiritual Factors in the Care of the Patient

RUSSELL L. DICKS
Chaplain
Wesley Memorial Hospital, Chicago

TO UNDERSTAND the chaplain's contribution to the care of the patient one must understand the nature of illness itself. My own understanding of the psychology of the sickroom and the care of the patient is drawn from an experience of having been a patient in 10 different hospitals; of having been operated upon seven times; of having worked in four hospitals; of having been associated with some of the nation's greatest, as well as poorest, doctors; of having spent literally hundreds of hours listening to physicians talk, both formally and informally, about illness, medicine and the care of the patient; of having written numerous pamphlets, articles and books, during which time through brooding, sweat and discipline I searched out and examined every insight, idea and conviction that I had ever come across which would enable me to carry on a more effective ministry to the sick.

The sum total of my findings concerning the nature of illness is that illness is basically, from the standpoint of the patient (and aside from the patient it has no meaning) a spiritual problem and health is a spiritual condition.

If it is true, as Harvard Medical School's late physiologist, Dr. Walter B. Cannon, has said, that "the human body is so constructed as to go on functioning almost indefinitely without becoming ill," we have to ask the question, why do we become sick? Medical science does not answer the question; religio-philosophy, which is not bound by the limits of science, offers a suggestion. It says we become sick, both physically and mentally, because of the inadequate ways in which we learn to handle our emotions of fear, guilt feelings and loneliness.

It is commonplace for the general practitioner to tell us that between 50 and 75 per cent of his patients, depending upon the kindliness and interest of the doctor, are persons without organic disease. The scientifically trained doctor, under the influence of modern psychiatry, now recognizes that a person who thinks he is sick is *as* sick, if not more so, as the person with organic disease.

Dr. Flanders Dunbar found that some 76 per cent of a large series of patients whom she studied at Presbyterian Hospital, New York, suffering from fractures gave evidence of having a psychogenic cause underlying the accident which led to their injury. Dr. Dunbar has said, "It is not a question of whether an illness is psycho- or somatic but rather a question of how much of each."

It is obvious that the illness which is psychogenic or even partially psychogenic has tremendous implications for religion, for religion deals with the interpretation of life and attempts to put meaning into living. To fail to help people who have problems of this nature is to fail as completely as if we failed to treat an organic disease.

For instance, I have never been able to understand the common practice of treating the organic symptoms of a person who has tried to commit suicide, pumping out his stomach, giving him intravenous fluids and fulfilling all the ritual of good physical treatment, and then sending the patient home without

Address delivered at American Protestant Hospital Association convention, 1947.

anyone's talking to him about what led him to the act. Since when has the problem of suicide been a physical problem, aside from how it is to be done?

Let us look at five great crises of illness and see to what extent they are spiritual in nature. These are physical insofar as the presenting problem is concerned. The first is the acceptance of one's diagnosis. The emotion of apprehension, or fear, is so great in connection with this crisis that many persons delay seeking a doctor's help so long that it is impossible for them to be helped when they do go to a physician, and in other instances it is so severe that the doctor withholds the diagnosis from the patient once it is complete, judging the patient as being unable emotionally to accept the information which the doctor has learned about him. This is a religious problem, for all religion teaches that we should be able to accept whatever experiences come to us and turn them into triumphant living.

It Is an Act of Faith

The No. 2 crisis in illness is the surgical operation. We are told by doctors that surgery is a matter of mechanics; the surgeon speaks of himself as a mechanic; the orthopedic surgeon, as a carpenter, the urologist, as a plumber. While surgery may be a mechanical process from the standpoint of the surgeon and his assistants, it is a spiritual process from the standpoint of the patient. For him it is an act of faith: faith in the surgeon, that he has the knowledge and skill to do the job before him; faith in the anesthetist that she will be able to keep him both free from pain and alive; faith in the nature of the universe, or God, to work through the healing forces of nature for his recovery.

At Massachusetts General Hospital in Boston we asked a large series of patients facing operation the routine question, calmly and casually, "How do you feel about it?" Approximately 90 per cent talked about religion, saying in words to this effect, "My confidence is in my surgeon and God." The surgeon got in ahead of God but then subconsciously the patients probably realized they had better be more concerned about the surgeon than God for they could be certain that God would not mess up the surgeon's work while the surgeon might mess up God's.

The third great crisis in illness is the prospect of facing life with a physical handicap following treatment: the person who has a heart attack and must live on a restricted physical activity regime the rest of his life, the person who has diabetes and must take insulin, the person with an ileostomy or colostomy, the person with an ulcer who must live on a strict diet, the person who has had infantile paralysis and is left with muscle weakness, the person who is blind, who loses an arm, leg or the use of a joint, and many others.

Aside from war casualties and great physical calamities like tornadoes, fires and such, where being wounded or injured is preferred to death, almost all other handicaps are interpreted as a special visitation from God. Even the sophisticated believe they have been singled out in some special way by the universe.

Mastery of and compensation for a physical handicap is a triumph in living by the spirit. We see many fail and fall short of an adequate mastery of physical limitation. Sometimes the failure is the fault of the patient's parents, friends or employers. Above everything else one must have hope, courage and perspective. These are attributes of religion, not easily come by but more than adequate when patiently and wisely sought.

The fourth crisis seen in the sickroom is that which may accompany a long convalescence when loneliness sets in, when the spirit dries up and the mind turns in upon itself. The radio, with its varied palaver, both helps and destroys the soul during such a time, and, I suppose, when television becomes commonplace, so many people will become sick, especially during the World Series, that there will be no one to care for them. Loneliness and boredom are emotional forces that may lead either to a destruction of the soul or into experiences of socialized and creative living. All religions agree that friendliness and trust are the very essence of religion.

The fifth and final crisis of illness is death. This so obviously is a spiritual problem for the patient that I need spend little time discussing it. Only religion has anything to say to the dying person; only religion looks upon this experience as a beginning and not an end, a possible triumph and not an absolute failure.

If the chaplain did nothing more than minister to the dying he would more than justify the cost of maintaining his work, judged from any standpoint you wish, particularly from that of the so-called hard-boiled scientifically trained physician, who is likely to fumble his care of the dying badly. He, above all, welcomes the chaplain's ministry to the dying and praises him eloquently when he obtains permission for a necropsy by simply pointing out to a family that that which they loved is no longer in the body and that what happens to it, so long as it is treated with respect, is of little importance.

He Must Have Preparation

What about the chaplain's contribution to the care of the patient, and how does he serve in the great crises of illness? When he knows something of the psychology of illness as described, plus the great emotions of fear, guilt feelings and loneliness, that may be found in persons who have no organic problem as well as in those who have, he may be of tremendous help. But the minister, priest or rabbi will not know how to carry on his ministry in the sickroom without special preparation for his task.

It is not enough to be, as a bishop described a minister he had appointed as hospital chaplain, with the approval but not at the request of the administrator, "a lovely person around the sick." Does "loveliness" of spirit, whatever in the world that is, ensure one of some judgment, some discipline, some skill? One might as well seek a surgeon who is kind and pleasant but who has never studied anatomy or served as apprentice in the operating room with an experienced surgeon.

The art of surgery is in knowing what to cut and what not to cut. The art of ministering to the sick is in knowing what to ask and what not to ask; what to say and what not to say; when to pray and when not to pray; when to leave and when to stay. The art of ministering to the sick is the ability to follow your leads, for if given the chance the patient will carry you to his need.

It is a safe estimate that some 50

to 75 per cent of the doctor's and the chaplain's work overlaps. That is to say, a patient would be equally helped by either a doctor or a minister, granted good nursing care; for both the doctor and minister are dealing with spiritual problems, both serve the same healing forces, both follow the same first principle of *do no harm,* for both know that if they can avoid doing harm most of their patients will get well. If they will cooperate, God, working through nature, will use them.

Welcomed as Allies

It is not the clergyman who has moved into the treatment of the body but the physician who has moved into the treatment of the soul, not just in psychiatry but in the whole of the practice of medicine. It is a demonstrated and well recognized fact that the physician welcomes us as allies when we work along sound lines; when we cooperate with him and do not work independently of him; when we are interested in the patient as an individual and not in the number of people we can get to agree to a prescribed formula which we interpret as meaning salvation regardless of the patient's mental attitude.

The doctor welcomes us when we fit into the hospital routine and do not act as little tin gods on a string. At one hospital where I worked I was told that if I could just stay out of trouble for a year it would be a major achievement because my predecessor was so thoroughly disliked.

Now as representative of the chaplains I have something to say to the administrators of hospitals, especially of church hospitals. To be sure we have made great progress in the last twelve to fifteen years in reinterpreting the subject of ministry both to the sick in the hospital world and to the clergy in general who come to the hospital to minister to their parishioners. In four years we have trained, or shared in the training of, 16 ministers now working as chaplains. Even so we consider it little short of a disgrace that so few of our church hospitals have chaplains, especially trained chaplains.

The clinical training program for clergy started in a state hospital for the mentally ill and the basic work of ministry to the acutely ill in general hospitals was done in a nonsectarian, private hospital. Some few hospitals have always had chaplains, particularly Lutheran and Episcopalian institutions, but there are only two Lutheran hospitals that offer clinical courses for clergy and the number of trained chaplains in Lutheran hospitals can be counted on one hand, while a large Episcopalian hospital recently voted to discontinue its chaplaincy program entirely, despite the administrator's efforts to the contrary.

Many other church hospitals either do not have chaplains or have men serving who are retired from serving local churches. We realize the administrators face a difficult task in selecting chaplains, but we have given you a set of standards by which to select and judge the work of a chaplain. These standards are for your guidance and protection. A notice last spring in the *Bulletin* of the American Protestant Hospital Association of the availability of a well trained young chaplain with excellent qualifications drew not so much as a single inquiry.

How the church hospital can justify being without a chaplain is beyond our comprehension. If illness is, as I have maintained, essentially a spiritual problem, the church hospital without a chaplain is failing in the very task for which it was established. To administer a hospital so is to be false to the church whose name your hospital bears, to say nothing of failing to provide a service to the patient which he desperately needs.

Lines About a Hospital

FOR months before The Modern Hospital was founded nearly 35 years ago, Dr. Otho F. Ball, its founder and publisher, talked the project over with the late Dr. S. S. Goldwater. From that time on, Dr. Goldwater contributed continuously from his vast store of hospital knowledge and wisdom to the development of this journal. In 1942, Dr. Goldwater wrote these lines on the train on his way home from a visit with Dr. Ball in Chicago.—The Editors.

S. S. G. to O. F. B.

On the Occasion of a Reunion

It's almost thirty years since you and I
Began to think in unison, and talk
Of what a hospital is and what it should be.
Well, thoughts like ours do not die a-borning
But, seized by eager wills, emerge as deeds
By which new shapes are formed, reshaped again,
Until the world about us is part Nature's,
Part our own.

Although we've not achieved
The perfect institution of our dreams—
Of love, and art and science all compact—
Rejoice we may, for we have lived to see
The hospital we cherish yield to change
From small to great, from careless to exact,
From home of sorry pestilence to proud
And comely scene of perfect cleanliness
Equipped with all that science knows to aid
Physician, nurse and sick, to whom in honor
We pledge again our faithful, firm support.

Orderlies Have Their Own Ideas

Here, one of them expresses his views on various phases of hospital administration

HARUN-AL-RASHID was the caliph of Bagdad who used to go among his people in disguise obtaining firsthand knowledge of their reactions to higher policy. Granted that he knew nothing of such concepts as the worker-in-his-work unit or aptitude measurement, he did know the importance of personal contact between top management and the worker. Indeed, Harun was a man who understood the meaning of personnel relations.

An administrator has neither the time to interview the worker nor the inclination to pursue the caliph's methods. The enlightened executive, therefore, seeks his knowledge through the medium of his department heads. However, the philosophy that "the door is always open" to the worker is almost as unsound as the caliph's extreme disregard for his executive staff. The purpose of this article, then, is to report, as objectively as possible, my observations while working as an orderly in a representative urban hospital.

"WERE I AN ADMINISTRATOR the first thing I would do is see that every orderly had a chair to sit on."

A rather simple remark. But, while the statement was made half in jest, the cause of it is worth investigating —it leads to two significant conclusions. First, it expresses a lack of recognition for the work performed. Then, too, the idea that there is nothing to the work of an orderly is immediately strengthened by the fact that no formal training is required for the position. I spent one day under the tutelage of an "old hand" and took over his shift the following day. This, incidentally, caused the experienced orderly to resign because he was transferred to the night shift.

This improper evaluation of the job, evinced in the lack of training required, is most important in terms of patient comfort and attitude toward the institution. The professional care expected of the doctor and the nurse creates a confidence in the patient that enables him to take a healthily objective view of his disability, a view that is often lacking in patient-orderly relationships.

While the orderly spends less time with the patient, he can make just as lasting an impression upon him as does the doctor or the nurse. For example, on my third day at work, I was told to go to another ward and report to a certain nurse. Upon arrival, she told me to give her patient a bedpan. In this, as in everything else, there is a definite routine —I found out later. Needless to say, it will be a long time before either the patient or I forget that experience.

Tipping System Vicious

Perhaps that is why patients are so likely to tip a considerate orderly. I don't know. But, I do know that the system is a vicious one. In every institution where tipping prevails the "customer" is eventually rated, and attention is given in proportion to his generosity. On one floor I accepted tips as a matter of course, then, upon transfer to another floor, I refused all tips, explaining that I was being paid for these services.

My experience indicates the necessity for serious consideration of some form of wage incentive system to eliminate tipping. Such a system will more than pay for itself in terms of patient and community good will.

EVERY BUSINESS has systems that have been installed to meet a specific need. All too often, however, these systems are perpetuated long after their purpose has been outmoded. A typical example of this is the requirement that all orderlies sign on and off duty in one of the executive nursing offices. Since

the hospital in which I work covers a considerable area, this requirement can absorb as much as twenty minutes of the orderly's (working) time.

There is no real justification for such a procedure. The ward charge nurse reports the orderly's time on her daily report sheet. To test the effectiveness of the regulation, I stopped signing on my second day of work. Nothing happened. I was never asked to explain my actions, and I'm still receiving my pay check. Yet, that time is still being wasted. Multiplied by total floors, three shifts a day, at the going rate it is a sizable amount per year.

MUCH OF AN ORDERLY'S TIME is spent in running various errands. Specimens have to be taken to the laboratory; drugs carried from the pharmacy; supplies delivered from the storeroom, and so on. While the majority of these trips are essen-

tial, the number of them could be decreased by a systematic requisitioning procedure. One day, I was sent to the storeroom for a mop head. The storekeeper told me it was necessary to have the requisition approved by the administrator before he could issue the item. When approval was obtained (from the administrator's secretary), I received my mop head.

From an orderly's point of view this incident caused only mild annoyance. But, from the point of view of a department head, few things are more exasperating. To delegate responsibility and to invest the corresponding authority in a secretary breeds dissatisfied and disoriented employes. Moreover, time consuming and annoying "safeguards" are wasteful, inasmuch as over-requisitioning to avoid an irksome procedure is the result.

THAT THE PSYCHIATRIC SERVICE is one on which the greatest precautions for the care of the patient and the reputation of the hospital should be taken, all administrators will agree. But, beyond warning me that the patients must be watched very carefully for their own protection, I was given no further instruction.

Shortly after I had been on this service, I was told to watch a patient while he shaved. He was given his own equipment, which included a conventional safety razor. The patient's first question concerned the quality of the blade. Since he had started to unscrew the razor I assured him hastily that the blade was new. This question, accompanied by the readjustment of the razor for proper blade tension, while causing me initial concern, was routine with all patients. Upon completion of his shave, however, he automatically took out the blade, ostensibly to clean it. Lunging for the blade, a natural reaction for an inexperienced person, might have startled the patient into an act that may not have been premeditated. Consequently, overt ignorance of his actions, accompanied by tense watching, was the only recourse. Fortunately, nothing untoward occurred.

During the time I spent on this service, four razor blades were taken from the nursing office (all at one time). Several months earlier, matches had been pilfered and a

bed had been set on fire. Both of these incidents, which occur not infrequently, could have been avoided: in the former case, by the use of either an electric or an injector type of razor; in the latter, by the use of lighters. With this type of equipment the nurse is furnished a better means of protecting the patient, and the orderly is relieved of a responsibility that never should be his.

TO INSTILL CONFIDENCE in a new patient about to receive shock therapy, the psychiatrist usually administers the first treatment, a good technic. Moreover, the patient is generally given oxygen immediately after treatment. One day, while we were waiting for a new patient in the treatment room, an orderly lit a cigaret. The nurse in charge ordered him to put it out, which he did. The psychiatrist brought in his patient, administered the treatment and ordered oxygen which was given by a nurse.

Throughout the whole procedure, the psychiatrist smoked a cigaret.

This was not an isolated incident. Unfortunately, physicians are all too likely to flaunt their authority by ignoring routine regulations which are basically sound and extremely applicable. Had an accident occurred, the doctor would probably no longer be in a position to suffer the adverse publicity that both the administration and the hospital as a whole would receive.

ANOTHER INTERESTING PROBLEM in staff relations is the time-honored friction that exists in most hospitals between the nursing and the dietetic services. This hospital is no exception, the tradition being enthusiastically maintained by both camps.

Conversations with students, graduate nurses and dietitians brought forth one reason for this friction that merits consideration. Again, it goes back to training methods. Students spend six weeks in the dietary department. They claim that it is here that an animosity begins which is carried on throughout the nurse's graduate career. Students feel they learn all that is offered in two weeks and are used the rest of the time as kitchen helpers.

This friction can be eliminated only by a long range planning program, which would include a revision of the students' training time. Joint administrative staff conferences, a proved success, would also do much to mitigate the situation. The cooperation to be gained by such a procedure would be reflected in increased dietary efficiency on the floors.

YES, WE SMILE at the caliph's methods, for modern administrative management is well on the road to effecting a compromise between the necessity for time to think in terms of broad policy and time to think in terms of the individual. Then, too, we of the lower echelons often express ourselves in terms of what we would do were we sitting in the administrator's chair. Nevertheless, I wonder sometimes if that chair is as comfortable as it looks.

Scientific Books Wanted

FINLAND has an excellent and keenly scientific minded technical institute, Teknillinen Korkeakoulu. During the war its library was bombed and totally destroyed.

On a recent trip to Finland for the American Friends Service Committee, I discussed the situation with Dr. Martti Levon, director of the institute. He said he would welcome gifts of scientific and technical books and periodicals from America to take the place of those destroyed. In the remarkable efforts for recovery that the Finns are making, the lack of technical library facilities is a serious handicap. It would be a practical act of friendship to a nation that holds America in high regard if Americans should contribute good technical books and periodicals to this library.

Any such gifts should be marked for the Institute of Technology, Helsinki, and sent to the Finnish Legation, 2144 Wyoming Avenue, N.E., Washington, D. C. Dr. K. T. Jutila, the Finnish Minister, will arrange to have them shipped to Finland.—ARTHUR E. MORGAN, *member, American Friends Service Committee, Yellow Springs, Ohio.*

The *Exit Interview* Is Your *Entering Wedge*

in establishing the personnel department

MARY SMITH

Assistant Superintendent, Monmouth Memorial Hospital, Long Branch, N. J.

ALL hospital administrators today recognize the need for a well organized personnel department, but many are hampered by not having the full time services of a person who is able to establish this department and make it function. Once a personnel department has had the opportunity to prove its value to the hospital, the expansion will follow easily but it is often difficult to insert the opening wedge. Therefore, if the part time services of a regular employe can be made available for establishing a personnel department, a practical place to start is the exit interview.

Procedures to Be Followed

An exit interview, as the name implies, is an interview held after any employe has announced that he contemplates leaving the hospital. From the standpoint of the interviewer, all or some of the following procedures are pursued according to the circumstances and the problem presented:

1. Establish rapport by allowing the individual to talk freely of what is on his mind and of the circumstances which have led up to his decision to terminate his employment. This relieves tension, tends to clarify any problems that may exist and gives the interviewer an insight into the way the employe is thinking and feeling.

2. Ask an occasional question to clarify a statement. In this way the interviewer can gain more information about any difficulty, the length of time the problem has existed and the methods already used in dealing with it.

3. Encourage the employe to think through the problem and suggest or help him discover other solutions than the one he has already decided upon, if this appears advisable.

4. Show consideration for the employe to be interviewed; take note of his good qualities and reassure him.

5. Ask for suggestions. This approach is often successful in winning cooperation and building self confidence as well as in bringing forth other enlightening facts about the institution.

As a method for ensuring that every employe who leaves is interviewed, we use the form on page 57 not only to record the fact that an exit interview was held but also to release the employe from the pay roll.

As soon as the employe gives notice of intention to leave, the head of the department completes the top two thirds of this slip and forwards it to the assistant superintendent. An interview is then scheduled with the employe through the department head and at the close of the interview the remainder of the slip is completed. This slip is pasted on the back of the pay roll card for a permanent record. On occasion it is not convenient for the interview to be held until the employe comes to call for his final check. If the interview is desired at this time, the personnel officer signs the release notice and leaves the date blank, indicating to the paymaster that this check should be held. The interview is then conducted when the employe calls for his final check.

All notations about an employe's reason for leaving, his pleasures and complaints are recorded on his application for employment record which is kept in confidential files in the personnel office. Epecially if the personnel department is in the process of organization, it is important to schedule the terminal interview as soon as the department head has learned that the employe plans to leave.

The exit interview allows the hospital to help the departing employe with any questions he may have, such as how to continue his Blue Cross coverage on a direct payment basis. He may be leaving the city and want his final check mailed, in which case he will address an envelope and the personnel officer will hand it to the paymaster. He may wish to know where to turn in his locker keys and how to get his key deposit returned.

Other Employes Will Learn

As soon as the interview is over and the individual returns to his department, other employes will learn that the hospital is interested in employe welfare. The employes who are not planning to leave but who have problems will soon find their way to the personnel department.

Many good employes have been saved from quitting by being helped to take care of their problems. For example, the employe may be leaving because she has no one to take care of her child. If there are nursery schools to which the child is eligible, one of these can be recommended; it is better to give the employe a day away from the hospital to take care of her problem than to be put to the expense of selecting, hiring and training a replacement. Also, if an employe feels she must leave to care for a member of her family who is ill, the case may be referred to a public health nurse who can come in for a short time daily and provide

the essential nursing care so that the wage earner can continue to work.

The exit interview, from the standpoint of the employe, serves as an orientation course for his new position in the community. Inasmuch as he is leaving the hospital, he will no longer be bound by the loyalty which existed while he was drawing pay. When he speaks about any happening at the hospital he will be looked upon as an authority, irrespective of the position held while he was there. It is of the utmost importance that he remember pleasantly the working conditions and that the ideals and standards which the hospital is trying to maintain be quite clear in his mind, inasmuch as he will be interpreting them to the community in general.

It Is a Service Organization

If the employe is leaving at the invitation of the hospital for some reason such as irregular attendance, we must make sure that he understands that the hospital functions as a service organization and is different from all other places he might have worked because the patients are entirely dependent upon us for every want. There is no way to send the patients home for their evening, night and weekend care and, consequently, we cannot function if we have unexcused absences.

It is also an established fact that the best employes are those who are recruited by satisfied workers. We can even go a step farther and say it is important to ensure that the consensus of the community is that the hospital is a good place to work so that the best qualified people in the community will make application. Much of this good will can be assured at the time an employe is leaving. The very fact that the "front office" knows he was here and gives him the courtesy of showing it cares that he is leaving will help him to remember us pleasantly, even though the way might have been rocky while he was here.

Many persons who come in to "help us out" should be thanked and their presence should be acknowledged. Those who are employed on a temporary basis to do a specific job should be thanked. One school nurse who did general duty at night during the summer was leaving and said that she had been working in various hospitals each summer since the start of the war but this was the first time her contribution had been acknowledged by other than a department of nursing.

One of the rules of our nurses' private duty registry is that all applicants work a month of general duty before being accepted to the registry. Exit interviews with nurses who will remain in the hospital as private duty nurses are always well worth while. They afford an excellent opportunity to chat about the various problems which we sometimes encounter with private duty nurses, such as shortages of linen for patients on floor care because private duty nurses appear to use linen excessively. Items of general interest, such as responsibility to the supervising head nurse and serving trays to the patient as soon as they are prepared, can also be profitably discussed.

Employes who are leaving for "more money" are usually eager to tell you where they are going and how much they plan to earn. This provides a constant check on the prevailing wages in the community for various classifications of personnel.

Exit interviews not only help ensure good public relations but provide a constant survey of what is going on in the various departments of the hospital. Many little "gripes" may not have been voiced previously to people who can do anything about them and when the employe is leaving he has the opportunity to ask "why" we do certain things as we do. It also gives a good audience to "Why don't they. . . ?" And these run the gamut from suggesting better elevator service to ideas for recruiting student nurses.

Cooperation Is Needed

Obviously, the cooperation of department heads is essential to the success of any personnel program; they may view a departure from established routines warily but they soon recognize that the attitude of the interviewer is one of not only listening to complaints but also correcting misapprehension whenever possible. Our department heads have been most cooperative and now provide complete information in advance of the interview as to the employe's reasons for leaving and any unusual accomplishments the employe may have displayed while on the job. It is apparent that they are spending more time in orientation of the employes because the exit interview has become a process of checking an employe's story of the hospital's function in the community and not one of telling it to him for the first time.

For example, the employe may now explain to me that he is leaving because this is a hospital and inasmuch as he was unable to do the job as required by the department head and the complete welfare of each patient is dependent upon having all activities timed like a precision watch it will be better for him and the hospital if he gets a job some place else. In this manner his dignity is saved because he understands fully why he is being released and he has told his story often enough to establish it. The exit interview provides a constant survey of the various departments and their administration. With the establishment of a per-

MONMOUTH MEMORIAL HOSPITAL

RELEASE NOTICE

Discharged ☐ Resigned ☐

TO PAYMASTER: Pay.....
Name of Employe Position

Is employe leaving in good standing? Yes ☐ No ☐

We would / would not reemploy. Last date worked.....

Empl. date..... Signed.....
Department Head

Exit Interview ..... 19.....

Personnel Officer .....

sonnel office and the routine for the exit interview, the recruiting of new employes has been enhanced in this hospital because there is one central place in which to make application. This is infinitely preferable to having the applicant shunted from one department to another to interview all department heads who are hiring or, worse, to be told that the department has enough employes when a neighboring department may be desperately in need of help.

Our next step is an orientation program to introduce all employes to the hospital, but these last two items, *i.e.* application and orientation programs, are not within the scope of this discussion. Likewise, no attempt has been made to present a discussion of why employes leave the hospital although some reasons are mentioned for illustration.

In our own experience, we have found that the exit interview requires a small proportion of one person's time when compared with the improvement in morale that results and the savings from the reduction in employe turnover.

They All Enjoy Cheerful Surroundings

ELIZABETH C. BERRANG

Assistant Director
Hospital of the
University of Pennsylvania
Philadelphia

A SPAN of two generations bridges many changes in industry, in commerce and in the arts, all of which minister in one way or another to man's comfort. It is probable that the last two generations have set a mark in this respect that was never equaled or even remotely approached.

The renovated pediatric ward of the Hospital of the University of Pennsylvania was laid out and equipped in the latter 1880's. What would the designer or architect of those days have thought had he been able to glimpse modern furniture and floor coverings, lighting fixtures, cubicle partitioning, germicidal lamps and other developments and inventions in physical accessories that, shall we say, are complementary auxiliaries to the modern hospital?

With his comparatively primitive facilities he executed well. And, although he may have felt the inadequacy of some of his implements and endeavored to improve them, I doubt if he ever thought of the psychological effect of color in an all-over decorative scheme. Improvements were made from time to time as science advanced, but the decision to renovate the old ward presented an opportunity to adopt the modern idea in decor: psychology of color.

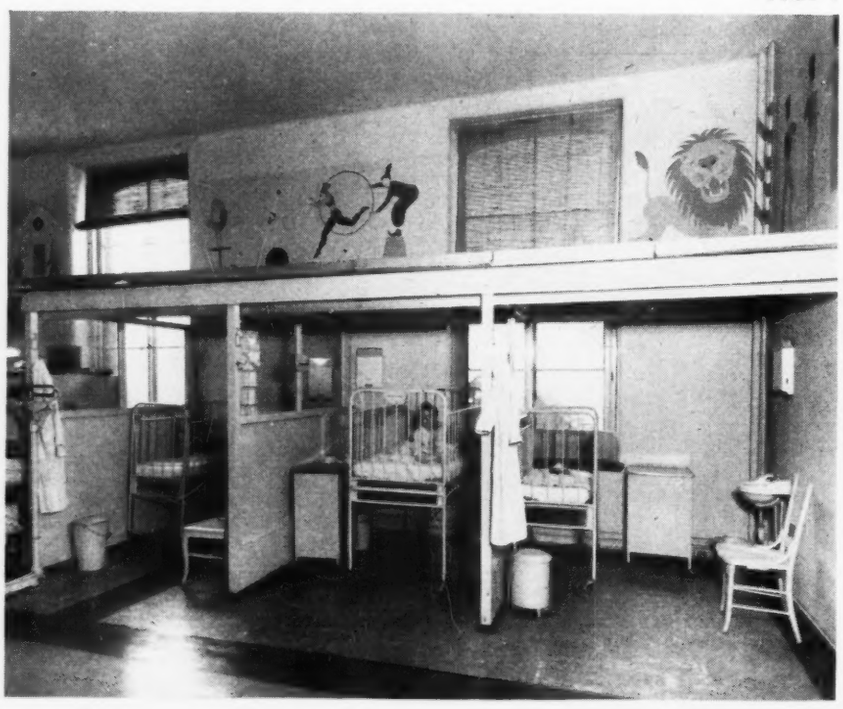
The ward is entered from the north through a corridor on either side of which are the usual auxiliary facilities: formula room, examination room, bathroom, linen room, kitchen, observation room and admission room. These rooms have not been changed except in one instance: a room was converted into a consultation area and was redecorated, but more about it later.

At the southern end of the ward is the solarium. The old ward (83 by 26 feet) was open save for four built-in cubicles, two at the northwest and two at the northeast corners. The nurses' station was in the center aisle midway between the ends of the ward.

In the rearrangement there are three isolation cubicles along the west wall beginning at the north wall (fig. 1), then a nurses' station and then six cubicles (fig. 2). Each isolation cubicle is equipped with a lavatory and hot and cold water; ultraviolet germicidal lamps under the lintels span the openings between the ward and the cubicles.

Also there are three cubicles along the east wall beginning at the north wall, and then there are 12 cubicles arranged in groups of four that are

FIG. 1



separated by partitions in the form of a cross. The supervisor's desk is in one of the cubicles in the first group of fours; it commands a full view of the ward.

Color predominates! The walls are a definite pink, the ceiling, a lighter tint, the furniture somewhat darker than the walls. The mural panorama just below the ceiling of circus characters—clowns, animals, acrobats, carrousel—is done in oil, in vivid shades of green, red, blue and orange and in black. These murals are interesting psychologically. They were obviously intended to add cheeriness to the room. That the children have been diverted and entertained cannot be denied, but the real "uplift" comes to the parents when they leave their children in such cheering surroundings.

Since color toning plays (and pays) an important part in the smart mood of today, why should not hospitals adopt it?

The pediatric consultation room (fig. 3) is one of the old rooms off the approach corridor, redecorated to meet the trend of the moment in color and furnishings. This room (16 by 14 feet) was used for admissions and interviews. It was unimpressive and drab. The walls and woodwork are now painted chartreuse. The fabric draperies have a motif of green palm trees on a background matching the walls. The old rough wood floor is covered with a composition tile in brown and tan. Over this is a soft beige broadloom rug.

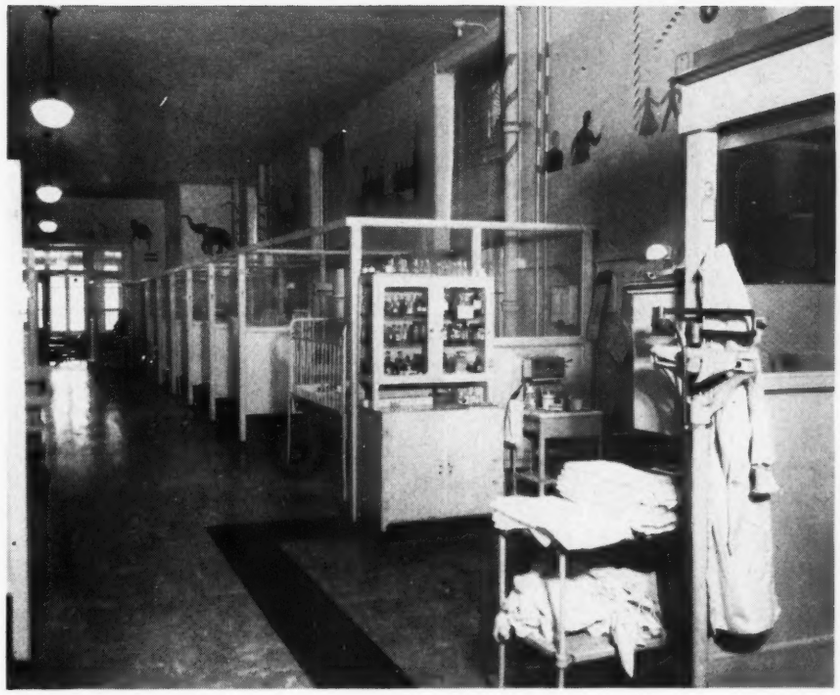


FIG. 2

Fig. 1: Three isolation cubicles are equipped with a lavatory with hot and cold water.

Fig. 2: The nurses' station and six more cubicles are arranged along west wall of the ward.

Fig. 3: The pediatric consultation room once drab and unimpressive is gay and cheerful.

Desks are fashioned of maple in blond finish. The chairs are similarly finished and are upholstered in chartreuse and green leather; a corner seat in maroon leather introduces a contrast. A cabinet, its color matching the walls, holds the books, record sheets and x-ray view box—essential articles, but unartistic when scattered around.

The bulletin board relinquishes some of its hereditary characteristics to blend with this ensemble. Finished in the some blond wood, it is really a shallow 2 inch cupboard with folding doors, on the face of which, to simulate a picture, are painted maroon flowers with rich green foliage. This deception is carried farther by a frame that surrounds the board.

This room is now used for many purposes: admission of patients, interviews, consultations, staff meetings and the monthly meetings of the women's auxiliary. The color and the modern furnishings have changed the whole appearance from an old room to one that has atmosphere.

This "face-lifting" is as superficial as its prototype, but it did something not only for the children and parents but for the doctors and nurses, too, who enjoy working in more cheerful surroundings.

FIG. 3

The Forgotten Male Nurse

CHARLES E. BERRY
Assistant Director
Mount Auburn Hospital
Cambridge, Mass.

IT IS unfortunate that the term "nurse" has become synonymous with "girl" or "woman." So universally has this interpretation been adopted that it is necessary to prefix the adjective "male" when referring to a man trained in the nursing profession.

Public acceptance of this usage has been a contributing factor in the rise of the belief that nursing is fundamentally a woman's task. This is not true; the male nurse has a definite and important place in the nursing service and may be the more desirable choice in some situations.

Male Nurse Is an Asset

In most of our present day hospitals there are many opportunities for the efficient utilization of the male nurse. Today, male nurses are usually found only in psychiatric, detention and genito-urinary sections of hospitals. Occasionally they are assigned to ambulances and, when available, they assist on all men's wards. In such units a man is a decided asset. Yet the value of the male nurse need not end here.

If a sufficient number of young men could be trained, they would prove invaluable in many other capacities. Their increased use on men's wards and as "specials" for male patients would be helpful in providing greater service to patients. Had we trained male nurses in years past, they could now relieve the thousands of army and civilian nurses at present staffing our government and veterans' hospitals, where the patient load is predominantly male. Many special hospitals, sanatoriums and convalescent homes seldom have been able to obtain a sufficient number of trained men.

In the average general hospital of 200 beds, the male nurse might be used to advantage in the blood bank, in central supply and in the plaster room. As a scrub nurse or nurse anesthetist, the male nurse could replace or augment present staffs, perhaps to great advantage where heavy lifting is necessary. One director of nurses reported that "my troubles would be over if I could find male nurses to take charge of the men's wards."

The popular belief that men are inherently coarse and rough, that they can never acquire the soothing touch, the gentleness and cheerful manner associated with a female is false. Does not the average physician possess these qualities? The properly trained young man with an aptitude for nursing can develop these traits just as does the young intern. The fallacy that men are naturally ill fitted for this type of work undoubtedly has been fostered by men themselves. Anyone who has been subject to the willing but often inadequate and unskilled treatment volunteered by the head of the household or by some untrained attendant or orderly has every reason to harbor this belief.

In considering the employment of the male nurse certain advantages and disadvantages must be recognized. The advantages of having a representative male nursing staff are many and varied. Many nurses of the opposite sex will probably take issue with me on this point, but it is a fact that some men more readily accept one of their sex, feeling less self-conscious and less restricted in their conversation and in their requests for attention to their needs.

Quite often brute strength is needed in subduing, transferring or turning a patient and when such an occasion arises a man is less likely to suffer from damaging sprains and injuries.

One of the contributing causes of the present scarcity of nurses is the failure of the graduate nurse to continue in nursing upon the completion of her training. The latest available figures, compiled in 1943, reveal that almost 50,000 graduate nurses were unavailable for duty. This was at a time when many married nurses had returned to work because their husbands were overseas or for other reasons resulting from war economy. Furthermore, 25 per cent of 31,000 army nurses questioned at that time expressed the intention of leaving the nursing field.

Committed to a Career

The young man who receives his R.N. is, in most instances, committed to a career. He looks to nursing for a livelihood, building his future upon this skill. It is no secret that many girls look upon their training as a means of self-support until they embark upon their destined career, that of marriage. Instead of the few years of service now obtained from many women graduates, we could expect a lifetime of service from the majority of male nurses.

There is no reason professional groups could not work together in complete harmony if the proper lines of authority were established. Certainly, sex has no bearing upon reliability. Efficiency is generally developed through training and practice. In men and women alike these qualities vary with the individual, but in meeting emergencies men can often undertake tasks too arduous for women. Such a mixed staff might also aid in solving the problem of providing adequate coverage

in the odd shifts so distasteful to most graduates.

There are, of course, some disadvantages in employing men as nurses, but these are neither numerous nor serious in a hospital in which good personnel policies exist. A man may dislike the idea of being supervised by women. He may further rebel at the "servant" attitude adopted by some doctors which is more or less accepted as professional license by most nurses. In the past male nurses have commanded higher salaries than those paid in hospitals but the trend toward adequate and more equitable salaries for all members of the nursing profession may minimize this difference.

May Be Influenced by Salary

As a group, male nurses may be unduly influenced by monetary and material considerations, giving these considerations preference when choosing a position. A man is less likely to be motivated by the high ideals that sometimes appeal to young girl candidates for training, but appeals based upon such a theme are, at best, of doubtful value today.

Before we propose a more extensive campaign for attracting male trainees, let us examine the facilities available for teaching male students. In 1945, 69 schools of nursing accepted males; three of this number restricted their enrollment to young men. It was not surprising to learn that in this same year only 169 men were enrolled in the schools that accepted them, for most eligible young men were receiving training in the armed forces. However, it was surprising to learn that in the so-called normal year of 1939 only 725 youths had the courage, and it took courage, to enter training for the nursing profession. This number represented less than 3 per cent of the total enrollment for that year.

If each of the 69 or 70 schools now accepting male students enrolled but 25 each year we would soon have a pool of approximately 1700 male nurses each year. Would it be overly optimistic to assume that 90 per cent of this number could be expected to remain in the nursing field for twenty years? How welcome would such a group be today, and will be tomorrow.

The recently intensified program for recruiting applicants seems to be directed exclusively to young women. Are we not neglecting an important source of prospective nurses in directing such publicity to one sex? Why not alter the public relations and recruitment programs to include some information and descriptive material that might stimulate interest among the thousands of male high school graduates searching for a career in these uncertain times? At least let these young men know that there is such a thing as a male nurse. Such a program would do much to dissipate existing prejudices and false conceptions. It would prove invaluable in breaking down barriers that cause men to hesitate before invading a sphere commonly assigned to women alone.

While the subject of a shortage of male nurses is seldom specifically publicized in the United States, concern has been expressed elsewhere. The following excerpt from the *Lancet,* a journal of British and foreign medicine, aptly phrases the point: "It is unfortunate that nursing as an occupation for men should be receiving such poor encouragement, for it seems likely that in the coming years some of our growing demand for nurses must be met by men."

In searching for a solution to the present nursing shortage, no possibility should be ignored. While not suitable for all types of nursing, men can be effectively utilized in varied capacities and yet little is being done to encourage those who might be interested. Despite this lack of interest in supplementing nursing ranks with young men, some few are attracted to this profession and have satisfactorily met all the requirements, as to both temperament and skill. Let's give the men a chance.

Hospital Beds Can Be Improved

by being made so that they can be lowered to a safe level

REGNER W. KULLBERG, M.D.
Astoria, Ore.

THE best hospital bed of today is not good enough. Nurses know that although the present bed is convenient for them when they are caring for the patient, it would be better for the patient if the bed could be lowered after the nurse's work is finished. There are some fine adjustable beds, but there is none that can be easily lowered below the standard height.

There are many reasons why we need a bed which can be easily moved up and down by one person or even by the convalescent or ambulatory patient. Older persons particularly would benefit from such a bed. On the basis of statistical estimates there will be, in the immediate future, an increasingly large proportion of older patients in our hospitals; therefore, we need equipment suited to their needs.

Elderly patients frequently sustain serious fractures when they fall out of the standard hospital bed now in use. If a guard rail is used, the danger is even greater, because the patient then falls from the height of the rail as he attempts to climb over it. Also, now that the trend is toward allowing both surgical and obstetrical patients to get out of bed early in their convalescence, it would be easier for the nurse to help these patients in and out of bed, if it could be lowered to a safer level.

Value of Lower Bed Is Apparent

If you have ever tried to help the short heavy type of patient out of bed, you will appreciate the desirability of a lower position of the bed. Moreover, the patient with heart failure, who must sit up part of the time on the edge of the bed, will develop less edema of the extremities if his feet are resting on the floor instead of dangling in the air unsupported. Such a bed would also

be a time saving device for the nurse, inasmuch as she would have fewer calls to answer from ambulatory patients who need assistance in getting in or out of bed. For reasons of greater safety, convenience to patient and nurse and improved hospital care, there is a great need for a bed which can be easily lowered to a safety level of 17 inches from the floor.

It is true that the present high bed is convenient for the nurse and doctor when care must be given to the patients. Hospitals, I am sure, will want this feature of convenient working height retained. Therefore, the bed we are asking for must be simply and easily adjustable. It must be light and easy to move. It must be easy to clean and be free of protruding, accident producing parts. It will have to be suitable for quantity production and should, of course, not cost too much.

The current development of mechanical devices in other fields gives us hope that before too long someone will design a bed such as we need. When we see the hydraulic lifts used in the various types of industrial equipment, we wonder why something like the hydraulic pump-jack used by the motor industry could not be adapted. Perhaps other devices, such as lever action, the elevating screw, the lazy tongs or the worm gear, are more suitable. Even a bed hung from the ceiling and adjusted by pulleys would be more flexible than is the type of bed now in use in hospitals.

At present the height of the springs is regulated by a primitive pin device. A clever use of coiled springs which could be compressed or released to the desired height may be the solution. The bed now in use could certainly be reduced in weight by the use of lighter metals, thus allowing for added mechanical devices. The elimination of the need for guard rails will be an additional worthwhile saving. In the past, patents have been obtained on adjustable beds, but none has been entirely practical for general use in hospitals. If someone with mechanical ingenuity will combine the best features of the beds already produced and add still newer features, hospital staffs and their patients will be grateful.

The Professional Touch Is Needed

to collect delinquent accounts

WILLIAM G. ILLINGER

Superintendent, White Plains Hospital Association, White Plains, N. Y.

MANY a lecturer on hospital operating costs and revenues has discussed at length wider use of hospital facilities, increase in patients' charges, better public relationships, increase in government aid, promotion of hospitalization insurance or a better method for soliciting contributions. All of these are aimed directly at the production of revenues.

The study of a method of increasing revenues is quite apropos now when conditions tend toward making their acquisition increasingly difficult. By the same token, the most efficient use of existing revenues should also be studied.

From the financial point of view, a most vulnerable point of attack on the hospital lies in the handling of accounts receivable. The public appreciates and respects efficiency in this department. The patient who encounters a loose system of recording charges, slowness in presenting complete bills and a general lack of office efficiency is quite likely to classify the entire hospital as similarly operated.

Most important in the handling of patients' accounts is to start out with a definite understanding as to rates and charges for extras. This may be accomplished by a booklet outlining them which is presented to the patient at the time of admission. This is also the best time to establish exactly who is to pay for the bill to be incurred. If possible, some directly interested person, other than the patient, should be induced to sign statements of responsibility for payment. Thus, a double sense of responsibility can be established much in the same manner that a banker secures his notes by insisting upon a co-maker.

As complete a personal history of the patient as may be practicable should be obtained. Particular note should be made of the employer (or business) name, address and telephone number. If the patient is with a large organization the department, phone extension and other pertinent information should be noted so as definitely to establish just how he can be reached.

Next, serious thought should be given to collection policies, particularly in view of the very high present day charges and the fact that money is not as loose today as it was during the years of war.

Let us assume that you have a reasonably good admitting policy and that patients are made conscious of the need to pay their bills on discharge. You will still find quite a number of patients who, for one reason or another, cannot or will not pay according to your policy. Thus, you are compelled to dun for payment.

Study the letters which you are now sending out, with two ideas in

mind: They should be strong enough to effect collection but, unfortunately, they must also be soft enough to protect your public relations. This places you in somewhat of a quandary. Would it not then be feasible to grade patients into two or three credit categories? For instance most private room patients could be considered in Class "A," most semiprivate patients, in Class "B" and ward patients would be in Class "C."

Volume Must Be Concentrated

Next, study the collection charges of two or three reputable and successful agencies. Consider the possibility of giving all of your business over to one, or not more than two. Your volume will govern which you decide. Few hospitals have enough volume to warrant the use of more than one agency. Bear in mind that hospital collections require special handling. In order to make such handling profitable (and therefore possible) to any agency the volume must be concentrated.

Most of these agencies have a sliding scale of rates. I shall quote from the one we are using. This agency charges 20 per cent if the account is turned over to it within four months of the last activity, either the date of discharge or the date of the last partial payment. It charges 33⅓ per cent if the account is more than four months, but less than one year old, and 50 per cent if it is more than one year old. In all cases, the charge is 50 per cent if the account goes to litigation. No charge is made, regardless of the amount of effort or disbursement expended, if no collections are made.

From this it can readily be seen that you can reduce your costs by stepping up your own efforts to collect within the first four months. Accounts approximating four months of age should be studied carefully to determine if further effort on your part will be reasonably successful or if that is a good time to decide to give them to a collecting agency.

Those accounts on which you have some reasonable assurance of effecting a collection in the near future can be held over to the full year and still cost only 33⅓ per cent, but most delinquent accounts can be pretty accurately evaluated within four months.

Hospitals have done such a good job of informing the public of their critical financial situation that a tightening up in collection policy should not result in nearly as much criticism today as would have been the case formerly. General public sympathy is all with the hospital, so proceed fearlessly and firmly.

A slightly different treatment of overdue accounts envisages the use of some young lawyer in your community who is not yet overburdened with a practice and would welcome a chance to make a few extra dollars in collection work. Any lawyer you select should have a sincere and sympathetic interest in your hospital. He should also be fairly cognizant of the type of people living in your community.

Fees Are Standardized

The fee is fairly standardized as recommended by the Commercial Law League of America, as follows:

18% on first $300
15% excess of $300 to $500
10% excess of $500
50% on claims of $18 or less
Minimum commission, $9

The suit fee is not contingent. It is in addition to commissions.

Suit fees: On claims of $33 or more, not less than $7.50.

The minimum schedule is intended to apply on current commercial claims, but on retail or difficult claims the minimum schedule is woefully inadequate; $7.50 is recommended minimum, not a maximum suit fee.

Before starting suit, attorneys should always arrange their suit fee to be commensurate with the services to be rendered *and the amount involved.*

The policy of the public institution, such as a hospital, is to reduce litigation to a minimum. Therefore, a substantial portion of suit fees will not be recovered. Suit fees on uncollected items will, of course, be a further expense without any return whatsoever. It would help considerably if it were possible to foretell accurately the outcome of any case. However, when seasoned credit and collection executives, who rely on their rich background of experience, are often surprised when a case is finally "cracked," what chance have we in the hospital to make accurate guesses as to which case will be collected and which one will not? We must rely on averages.

In considering average commissions and suit fees charged by the attorney and average commissions charged by the agency, our feeling is that the agency cost has a slight edge over the attorney cost. Two further important considerations influence our decision in this respect. First, the attorney will not have the facilities for personal contact so important in collections and in tracing delinquents. He is not in a position to minimize litigation and at the same time produce results. Second, collection items, for the average lawyer, are not a vocation; they are stepping stones to bigger things. Usually, a competent attorney will develop his practice in a year or so to the point where he can no longer devote adequate attention to collections. Thus, the arrangement is more or less temporary.

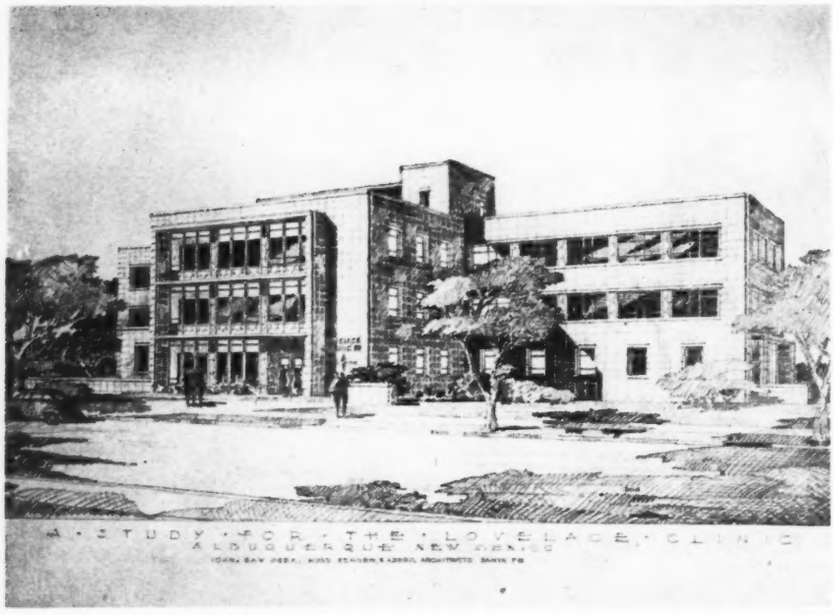
However, do not take for granted the services of any collection agency. It is true that it will write several letters, but if it is a good agency, it will also make personal calls. It would be well to have a heart to heart talk with the representative to relieve any anxiety in your mind as to the handling of your delinquent accounts. The agency may dig up a few bona fide hardship cases and should be made to understand that it should relinquish these at once with its recommendations, and no charge should be made. It naturally follows that you must give the agency a substantial amount of your business to make that phase of its work worth while.

Safe in Giving Out Accounts

Once you are certain that whoever is to handle your collections will protect your public relations interest, you can be quite safe in routinely giving out those accounts on which you feel you have made every reasonable effort to collect.

In conclusion, the agency selected should be regarded as a department of the hospital. As such it operates within the scope of the hospital collection policy yet derives its operating expenses through its fees. In this connection it should never be forgotten that, as with so many other things, the cheapest is not always the best. Always consider that cooperation in spirit, as well as in letter, depends upon both sides benefiting by the association.

Your goal is to accomplish results with a minimum of friction in public relations.



Architect's rendering of the projected building for the Lovelace Clinic at Albuquerque, N. M. Architects for the clinic are John Gaw Meem, Hugo Zehner and Associates, Santa Fe.

Lovelace Clinic takes the first step toward its goal:

Medical Center of the Southwest

ESTABLISHMENT in Albuquerque, N. M., of a $1,000,000 philanthropic foundation for the advancement of medical science was announced recently by Dr. William Randolph Lovelace, for many years head of the Lovelace Clinic there. The new organization will be known as the Lovelace Foundation for Medical Education and Research. It will have assets valued at $1,000,000, consisting of the entire property of the Lovelace Clinic, a group of practicing physicians well known in the Southwest.

Follows Mayo Precedent

The foundation will be operated at the outset from the earnings of the doctors in excess of operating expenses. This unusual method of turning income derived from the sick to the benefit of humanity follows the precedent set by the Mayo Clinic and a few similar medical groups which have established such foundations.

Organizers of the foundation have stated that it is to be conducted "in the broadest and most liberal manner" as an educational, research, scientific and charitable organization, not for profit. Explaining the foundation's plan to conduct research in the causes, prevention and treatment of diseases, Dr. Lovelace said:

"It is our hope that we can help make Albuquerque the medical center of the Southwest. New Mexico's climate always has been an attraction to the sick and has enabled many coming here to recover their health and become prosperous and distinguished citizens.

"We have, on the other hand, lacked the kind of research and training facilities common to the more populous sections of the country. These attract great numbers of the doctors who are most interested in increasing their knowledge and improving their ability. Such men are needed to provide the finest care for the increasing volume of persons expected to seek new opportunities in New Mexico.

"The best in nature and the best in medicine should go together."

One of the Lovelace Foundation's major interests, he said, will be the study of the apparent beneficial effects of Albuquerque's sunshine and moderate temperatures on arthritis, sinusitis and diseases of the chest. Another aim is the expansion of the clinic's cancer detection and treatment service both for its patients and for those referred by other physicians.

A further objective, and a basic function of the foundation, will be the awarding of fellowships enabling young doctors to take postgraduate training at the clinic in preparation for recognition as qualified specialists. This training, it is planned, will be conducted through affiliation with an approved medical school. Dr. Ward Darley, dean of the University of Colorado Medical School at Denver, is a trustee of the foundation and will be a key adviser in the formation of the training program. The Lovelace Foundation will not engage in the practice of medicine. This is the function of its sponsor, the Lovelace Clinic, allied hospitals and medical services and the medical profession in general.

Plan Aeromedical Research

Among others associated with Dr. Lovelace on the clinic and foundation staff is his nephew, Dr. W. Randolph Lovelace II. The younger Dr. Lovelace, who was formerly on the surgical staff of the Mayo Clinic, is a faculty member of the Colorado medical school. One of the world's outstanding authorities on aviation medicine and during the war director of aeromedical research at Wright Field, Ohio, Dr. Lovelace is now transcontinental and international medical director of Trans World Airline and a member of Gen. Carl Spaatz's scientific advisory board of the Army Air Forces. An aeromedical research program is planned for the foundation.

Legislation and Problem Drinking

JOSEPH HIRSH
Associate Director
Research Council on Problems of Alcohol, New York City

Whenever a disease is so widespread in the population, so serious in its effects, so costly in its treatment that the individual unaided cannot deal with it himself, it becomes a public health problem.—THOMAS PARRAN, *Surgeon General, U. S. Public Health Service.*

THE problems of alcohol and particularly their most dramatic component, problem drinking, fit every facet of Dr. Parran's definition. There are seven times more cases of alcoholism than there are of tuberculosis. The lives of 3,750,000 chronic and excessive drinkers are directly affected; a minimum of 12,000,000 people — family, friends, employers, employes, associates — are indirectly affected. One expert estimates the cost of alcoholism to these individuals and to society to be one billion dollars a year.

A Story of Neglect

The story of the problem drinker is consistently one of medical and social neglect — of little understanding of his difficulties, of few hospital and clinic facilities, of lack of medical interest, of destitution and inability to obtain what little care may be available.

The government has many ways of coping with alcoholic excesses: prohibiting the manufacture and sale of alcoholic beverages, restricting the times and terms of sales, limiting the alcoholic content, imposing severe penalties for excesses, instilling the values inherent in moderation and developing adequate programs of medical care for the tragic victims of excess. Few states have developed a comprehensive program embodying all these principles. Many of them, however, have made some provision, primitive though it is, for handling problem drinkers.

Under the law in many communities (in most states) the problem drinker is handled in one of two ways. As a misdemeanant — not a patient — he may be sentenced to jail or the workhouse as an offender against public order. Otherwise he may be committed to the state hospital for the mentally ill or to a special hospital, farm or industrial colony for inebriates.

Maine, a striking example of the moralistic, medieval tradition of the alcoholic-criminal-sinner doctrine, commits her problem drinkers to "reformatories" or "houses of correction" in the company of "rogues, vagabonds and idle persons going around the country begging; persons using any subtle craft, jugglery, or unlawful games or plays, or for the sake of gain pretending to have knowledge of physiognomy, palmistry, to tell destinies or fortunes, or to discover lost or stolen goods; common pipers, fiddlers, runaways, nightwalkers, railers, brawlers and pilferers; persons wanton or lascivious in speech or behavior." In keeping with this tradition, inebriates in Maine may be committed to the custody of guardians who, in turn, may "bind them out to labor for not more than six months or to employ them in their own service, giving them credit for their earnings."

With the outbreak of World War II, 24 states had, at least in theory, a more advanced view of caring for problem drinkers or inebriates, as they are usually termed in the law. Although seldom or inadequately invoked, there are in these states statutes calling for hospitalization of inebriates either in state mental hospitals or in licensed private institutions.

Well intentioned though they are, and advanced in comparison to the laws of Maine, these statutes are misconceived.

First, many of them were enacted at a time when a quick cure for compulsive drinking was thought possible. As a result, voluntary admissions range from two to six weeks and commitments, from six months to a maximum of three years. In practice both types of patients, with the exception of the psychotic alcoholic, are usually short term, rarely long enough to avail themselves of little more than sobering up and emergency care.

Hospitals Refuse to Admit Them

Second, state mental hospitals use "administrative discretion" in refusing admission to nonpsychotic alcoholics. Understaffed and overcrowded as they usually are, these hospitals usually take advantage of their discretionary powers. Lack of sufficiently well trained psychiatric personnel, special facilities and the shortness of stay of many compulsive drinkers militate against individual and group psychotherapy.

Third, mental hospitals — public and private — are rarely the institutions of choice of problem drinkers or their families. Much as they cotton to the idea that problem drinking is a disease, they prefer to view it as a physiological abnormality (which indeed it may be in some cases) similar to ragweed, shrimp or strawberry allergies or to the sugar intolerance of diabetes. They resist any suggestion that it may be a symptom of mental instability. Mental hospitals tend to buttress the fears and to reinforce the insecurities many problem drinkers have. They continue to set these patients apart from the society they do not understand or which they feel does not understand them.

Condensed from a chapter in Mr. Hirsh's forthcoming book on problem drinking to be published by Duell, Sloan & Pearce.

Within the last decade several states, notably Montana in 1935 and Iowa in 1939, have grappled with the problem of long term psychiatric treatment for compulsive drinkers. The Iowa law permits committed inebriates to "be retained in custody until cured." The Montana statute has an additional kicker—an and-or-until—the superintendent is "satisfied that such person is not receiving substantial benefit from further hospital treatment."

California went one step farther. The Inebriate Colonies Law provides for the establishment of one or more institutions for the sole purpose of the care and rehabilitation of chronic inebriates.

Followed "Hands-Off" Policy

In general, this was the limit of society's accepted responsibility toward the problem drinker prior to the war. General hospitals offered little assistance and that in emergencies, reluctantly. They stood firm with their hands-off-alcoholics policy. Literally only a few score private and expensive sanitariums and "rest farms" existed to meet the medical needs of hundreds of thousands of problem drinkers.

This deplorable state of affairs brought forth a blast from the American Hospital Association in 1944. In the foreword to its survey of institutional facilities for the care and treatment of these patients, Dr. E. M. Bluestone stated:

"Most of our hospitals have thus far failed to dignify alcohol addiction as a disease worthy of study and intensive care. They and their medical staffs are preoccupied with the acute phases of disease and manifest a tendency to withdraw from its long term phases. They and the medical profession are, indeed, so absorbed in the pressing problems of purely physical disease that they play into the hands of a sanctimonious group in our midst, who would have such patients 'stew in their own juice,' who have no sympathy for scientific medical approach to this peculiarly baffling malady.

"Every kind of patient has been provided for, in one type of hospital or another, including the leper, whose traditional position as an outcast has not deflected us from planning for his care. Doctors and hospitals have been gravely remiss in the duty of breaking down these unsound, uninformed public attitudes toward the alcoholic. The problem deserves the aid of the best medical brains and of the use of the facilities of every hospital.

"The jaunty sobering-up treatment in the emergency room, which is apparently undertaken because it is inescapable, is the limit of our interest in alcohol addiction in many hospitals. It is symptomatic treatment based on a snap diagnosis. It is often hurried, haphazard, faulty and, above all, superficial in method and results. The patient suffering from alcohol addiction is too often consigned to the police or, still worse, left to his own devices without constructive aid from doctors or hospitals, unless he is a man of wealth, in which case he can obtain private care of a palliative sort. If he is poor, he is doubly cursed. In his weakness he gets kicked around not only by society but by those of us who, in our hearts, should know better. We must not lull ourselves into believing that we can dispose of the problem by pleading that we have other work to do for those whom we consider more deserving. This kind of patient needs our sympathetic care like all other sick patients to whom we hold our doors and our arms open."

The war accentuated America's psychiatry-mindedness. A rash of writings ranging from Are-You-a-Neurotic, on the one hand, and Be-Glad-You're-a-Neurotic, on the other, to What-to-Do-With-Your-Returning-Veteran had done their work. "The Lost Weekend" was hailed by a public obviously relieved to be able to shout about something that had been, until they read the book and saw the film, a strictly private worry.

Problem Out in the Open

Spurred on by the "Weekend's" success and the recognition given it, more books appeared, new articles, new movies, banner newspaper headlines, autobiographies, novels, scientific and popular documents. Problem drinking was stated and restated in simple human terms, in terms of returning veterans who became wayward husbands and waiting wives who used the bottle to make the wait shorter; in the social terms of delinquency, divorce and crime. The theme was repetitive. But the repetition was important for it battled hundreds of years of ignorance, apathy and shame. *Alcoholism is a sickness and alcoholics are sick people in need of medical care.*

Actually, this "new" approach was proclaimed in medical circles almost 170 years ago and suggested many times long before that by the various authors of the world's best seller, the Bible. But the voices were never heeded.

The cause of the problem drinker — unlike the mental hygiene movement with its Clifford Beers, the social hygiene movement with Drs. Snow and Parran, the Red Cross movement with Dorothea Dix and the infantile paralysis movement with Franklin Delano Roosevelt — had no single, shining champion. Certain silent, anonymous sufferers who had found their own salvation were willing to devote their lives to saving others. Not offering it as the only or even the best solution, Alcoholics Anonymous was among the first groups to call national attention to the plight of the problem drinker and to the medical nature of his ailment. Sincere and very often effective, these persons carried a message of hope and humanity, and a few in America listened.

States Take Action

A number of states acted. Oregon set up an investigating commission in 1943. Following its report, submitted in 1947, it was given $115,000 "to establish and maintain . . . a rehabilitation clinic. . . ." New Jersey, Alabama, Connecticut — all in a matter of months — during 1945 established commissions as permanent arms of the government either to study the problem, to plan medical programs, to conduct educational programs or to establish medical facilities for the care of problem drinkers. (New Hampshire's 1945 interim commission became permanent in 1947.) Some of these commissions were set up to undertake all of these activities.

By 1946 the legislative epidemic had spread all over the country. The infection reached even one of the three "dry" states — Mississippi — which set up *separate* and *special* facilities in the "State Insane Hospital" for "all persons suffering from the effects of alcoholism." The new law charges furthermore that, when suitable accommodations have been made . . . all such patients now confined in any institution of the state shall be transferred thereto . . . ."

In 1947 Utah and Wisconsin established permanent commissions. Almost half of the states considered a score or more bills designed to meet the unmet medical problems of compulsive drinkers. Despite the welter of other "more pressing" legislation, nine of them became law. In addition, a number of temporary investi-

gating bodies were set up, in Maine, Massachusetts, New York and Virginia.

The 1946-47 legislative session may well have been the proving ground for the future. A brief review of the bills considered and the agencies of government established to cope with problem drinking may serve as a useful guide.

California attempted in its recent session, though unsuccessfully, to establish a "Commission on Alcoholic Rehabilitation" as part of the state department of mental hygiene.

In Idaho, a "Narcotics Research Fund" was set up to conduct education on alcohol through the state board of education. The costs of operating this activity are to be defrayed by a 0.5 per cent tax added to the cost of liquor. Iowa and Montana also set up educational programs. Illinois established a continuing "Committee on the Problem of Alcoholism" charged with conducting research, treatment and prevention. One building at the Chicago State Hospital has already been set aside for these purposes.

Nebraska Was Conservative

Conservatively, Nebraska enacted legislation providing for "care and treatment of persons addicted to the use of alcoholic liquors and narcotic drugs . . . for voluntary application for admission by patients suffering from liquors or drugs to state hospitals."

Acting on the findings of an interim commission appointed in 1945, new legislation was passed in New Hampshire establishing a comprehensive research, treatment, prevention and educational program.

In New York, the governor appointed an Inter-Departmental Health Council committee (representatives of the state departments of health, social welfare, education and mental hygiene) to report its findings of needs and its recommendation for a program of action.

In Oregon, the powers of the liquor control commission's permanent educational advisory committee were expanded "to establish and maintain . . . a clinic . . . as a rehabilitative agency and treatment center for persons addicted to the excessive use of intoxicating liquor."

In Pennsylvania, $50,000 was appropriated to conduct research, treatment and training of personnel to care for problem drinkers in a Philadelphia medical center.

In Utah, a five man board was created . . . to investigate the causes of alcoholism and to provide education thereon and treatment of alcoholics.

The bureau of alcohol studies, in the Wisconsin State Department of Public Welfare, was created to (a) cooperate with existing governmental and private organizations; (b) conduct, promote and finance research; (c) establish treatment facilities; (d) give financial aid to communities to encourage the development of new facilities.

With the establishment of governmental agencies to cope with problem drinking between 1945 and 1947, somewhere in the vicinity of $750,000 has been allocated for research, treatment and education. If the budgets of the major private agencies were included, under $1,000,000 has been expended in the interest of problem drinkers, compared to the $130,000,000 spent each year in tuberculosis control.

Of the hundreds of bills concerning liquor considered in 1946-47 by state legislatures and the national Congress, only a score or more dealt directly with problem drinking and those suffering from it. Fewer than a dozen states now have permanent commissions to cope with this problem. As many more have temporary commissions or other bodies charged with the responsibility of determining the scope and nature of the problem and of submitting a program to the next legislative sessions. In these states at least within the next few years citizens will be given the opportunity to decide on a problem that does not affect their fellowmen alone but themselves. How then shall they decide?

Many hospitals, past, present and planned, are frankly a disservice to problem drinkers, offering incomplete care in a separate and artificial environment. Emerging from them, physically recovered but emotionally unstable, many of these alcoholics are poorly prepared to live at home and to participate in everyday community living. Unless public hospitals are prepared to provide comprehensive care without stigma, medical, psychiatric and rehabilitative, the public would do well to limit facilities to the acutely ill, to those in a toxic state and to those with concomitant injury or illness: broken bones, vitamin deficiencies and various constitutional disorders. The costs of new hospital construction being what they are, ranging as high as $26,000 a bed compared to $9000 a bed before the war, this is a hard reality.

Until such time as sufficient scientific knowledge is gained concerning the institutional requirements of problem drinkers, until more is known about diagnosis, treatment, prevention and rehabilitation, the large scale building of special hospitals is not warranted. The interest of the problem drinker, as much as the public interest, will be better served by a program embodied in the following principles:

1. Provide effective training of medical students, interns, resident physicians, specialists, nursing and other personnel into the nature and needs of problem drinkers.

2. Require all public hospitals by law, and encourage private general hospitals, to open their doors to both acutely and chronically ill patients.

Provide Essential Information

3. Establish a limited number of specialized centers connected with medical schools and their affiliated hospitals (to ensure the highest quality of professional personnel and facilities), providing hospital and clinic service. These centers would focus all of the medical and correlative sciences on the patient not merely in providing treatment and rehabilitation but also in discovering basic information concerning his condition, how it came about and what can be done to prevent its recurrence. An inherent function of these centers should be the teaching and training of medical and nonprofessional personnel working with problem drinkers. These centers can provide essential information also on the problems of management, administration, cost, number of patients (clinic and hospital) which they can handle adequately and their effectiveness. These are matters of which we have little or no information and which are of prime importance in the creation of any public program.

Research into the causes of problem drinking, into effective methods of treatment, the development of prevention and rehabilitation programs, adequate medical facilities

for these patients, and education — the elements of a comprehensive program — are not the pet dreams of scientists, doctors and reformers alone. If this disease is to be licked and its victims are not merely to be treated but helped to reestablish themselves in society, all of these elements must be brought into play simultaneously. In this we must be of one mind, for anything less than a total attack on the problem would be waste.

The formulation of remedial legislation, therefore, calls for a national program of research under governmental and private auspices, such as the United States Public Health Service, the National Research Council, the American Medical Association, the American Hospital Association, the American College of Surgeons, in their standardization programs, and other professional groups. It calls for such federal support in the form of grants-in-aid to the states and to individuals for institutional facilities and research programs as are needed. It calls for state authorities planned along the lines of the commissions now operating in some states. These authorities must provide comprehensive care in hospitals and clinics for voluntary and committed cases. They must recognize research and education of problem drinkers, their families and the population as a whole as basic to any program of prevention and control.

Beginning with the tithe of the excise on liquor which partially supported the New York State Asylum for Inebriates, revenues from the manufacture, sale or licenses on liquor increasingly are being looked to for the support of medical programs for the problem drinker. The theory, as yet unsupported, underlying this practice is that alcohol is the sole cause of alcoholism. Make marriage licenses pay for the operation of divorce courts and arms manufacturers pay for police protection, the argument may run. That theory has never really been aired — for obvious reasons.

Liquor Interests' Position Weak

True, the liquor interests are in a poor position, psychologically and in fact, to protest. They are the butt of public opinion. They have made fabulous fortunes in recent years. Taxing these fortunes seems natural. Larger license fees seem sound. They not only provide funds for a humanitarian purpose but cut down the number of socially irresponsible licensees. Subject to these special aggressions and a little fearful, the industry takes a practical view of these proceedings. The manufacturers like to think themselves noble humanitarians supporting education, health services and other "good works." But all the while they are privately unhappy over what appears to be an official stamp of recognition of the relationship of alcohol and alcoholism.

The "drys" are also queasy, but for different reasons. They see liquor "here to stay" and the state "joining hands" with the unholy. But the sources of funds and the "whodunnit" aspect of problem drinking are secondary and easily soluble. Our primary concern is that the solution, when effected, be sound in mind, body and spirit.

With liquor taxes and license fees going into the general tax fund supporting all public programs, no special group or interest can be charged with creating or credited with the solution of problem drinking.

Hospital Design in England

HOSPITAL construction is in a state of transition—it always is, of course. After a comparatively static period following the Nightingale era, real advances seemed to be occurring during the ten years preceding World War II; but the outbreak of war brought a lull in construction and there is now uncertainty about hospital policy. We have, in fact, arrived at the crossroads in the principles of hospital building and there is need for intimate discussion between doctors and architects — not to speak of nurses and patients—during the lull so that our ideas may be clarified.

The position was outlined in the history of medicine section at a meeting of the Royal Society of Medicine when C. E. Elcock, F.R.I.B.A., opened a discussion on "Hospital Building — Past, Present and Future." The problems fall into two groups: questions of policy, such as function, size and location, and questions of architectural layout and detail.

As to location, Dr. R. C. Harkness said that the London County Council experience made it clear that a hospital must be in the area it is to serve if it is to be used to the full. Mr. Elcock, on the other hand, felt that space, freedom from noise, fresh air, sunlight and low costs weighted the scales heavily in favor of country sites. His main point, in which naturally he had the support of medical officers of health, was that the building for the sick must in future be a part of a local center for preventive as well as curative medicine.

A new idea was embodied in the Harvard Hospital (somewhere in Wessex) which was a base for a field unit with its laboratories combined with a hospital for infectious diseases. Mr. Elcock favored the policy of using hospitals for education in healthful living; the building was as important as what happened inside it.

As regards size it seems clear that the day of small, scattered special hospitals is over. For historical reasons, the isolation hospital, sanatorium and maternity hospital rose independently; there is no reason why they should not now be grouped and the isolation of their medical and nursing staffs ended. This would accentuate the importance of circulation. Mr. Elcock claimed that his continuous veranda type of ward, with beds parallel to walls, ensured a far larger amount of sunlight per patient.

On one point both architects and doctors were agreed—the need for specialization in hospital construction by both professions. The day of the benevolent amateur is over. The local architect's plans, adapted by clinicians with the matron called in as an afterthought, produce a building which is often more cottage than hospital. The Emergency Hospital Service has revealed the need for specialist hospital officers. The effective coroner is a blend of doctor and lawyer; should not the central authority, at least, have on its staff a doctor who is qualified in architecture?

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The Aged Are Individuals, Too

and their individual needs and capacities must be taken into account by the medical social worker in planning for their care

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A FIRST step in medical social planning for older patients is to free our thinking from the misconceptions which arise from viewing the aged as a group to which certain characteristics are categorically attributed.

In her work with chronically ill older persons, the medical social worker needs to retain, by conscious effort, if necessary, the same individualized approach to the medical and social problems of a particular patient as she uses with younger persons. This becomes doubly imperative in view of the probable lack of interest in this individual which may be manifested by the doctor, the nurse and even the family and friends. The effort to obtain a clear understanding of the medical social need as the basis for individualized planning may be still further hampered by the uncertainties of prognosis or the slow rate of deterioration.

The keynote, then, of medical social planning with the aged sick is the keynote of social case work: an individualized approach to the patient, which is founded on the worker's knowledge of human behavior and its motivations and on her skill in professional relationships. This implies recognition and acceptance of the fundamental principle that the aged person's response to his medical problem will be no different from that of any other adult in being determined by his life experiences and the meaning they have had for him. Both his need and his methods of responding to it, however, may be affected and accentuated by his age. For this reason there would seem to be value in considering more particularly the social and psychological problems which naturally accrue to the older person.

From a paper presented at the Tri-State Hospital Assembly, 1947.

Foremost among these are the sense of loss and insecurity which come to older persons from the deaths of close relatives and friends and from the breaking of family ties through the marriage of children or their employment elsewhere. Inevitably, the older person, unless he has been alone in life for many years and has achieved a satisfying adjustment to his aloneness, will more or less constantly have a certain amount of anxiety about the imminence of such losses and separations; his apprehension will be in proportion to the depth of meaning these relationships have had for him.

When chronic illness of a severely incapacitating nature threatens to separate the patient physically or psychologically from his family or to isolate him from the few remaining ties he may have, the medical social worker faces the probability of extreme anxiety and depression, plus the possibility that the patient may resist all efforts on his behalf which would remove him from his home or circle of friends.

Such reactions are commonplace at any age. One notes them here because of the likelihood of a greater intensity of feeling in older persons, and the greater difficulty of offering satisfactions which can adequately substitute for the real and irrevocable losses the patient experiences or allay the anxiety natural to an expected downhill progression of the disease.

Closely associated with these anxieties and insecurities of old age may also be a feeling of uselessness. Many

Photograph by William Rittase

Emphasis should be on preventing social strains and conflicts in the aged.

writers today are stressing the unfortunate psychological connotations of "retirement," especially to the person who has experienced no lessening of intellectual or physical capacity. Physicians also are taking increased cognizance of the bearing of a sense of futility, frustration or boredom on the incidence of somatic complaints in their older patients. This is an area of special interest to medical social case workers both in its implications for preventive effort before the onset of disease and in lessening the tendency to use physical illness to develop regressive substitutes for the essential satisfactions of feeling needed and wanted.

Unconsciously Prolongs Illness

To the economically deprived or to the emotionally needy person, the comfort of adequate physical care or the satisfaction of interest and attention may offer a degree of security which leads the patient unconsciously to prolong his illness. We are becoming increasingly aware of the importance of these satisfactions at any age period; their value may be proportionately greater with the added insecurities and deprivations of age, poverty and meagerness of opportunity for compensatory gratifications.

The case load of the medical social worker in any general medical care setting affords numerous illustrations of the reactions common to most persons when confronted with loss of capacity for self directed, productive living. When to this fundamental and natural anxiety is added the further insecurity inherent in old age itself, one may expect behavior consistent with the responses a given individual has made to other situations which have threatened his solutions to the pressures and traumas of life.

The essential point for our consideration is that the individual's responses (except in mental illness) will not be changed but accentuated by the process of growing old. As Dr. Edward Stieglitz has so well said, the process of aging stresses certain dominant traits; it blurs and lessens others. Basic personality patterns remain unchanged: "The tolerant and wise become more so; the fool becomes an old fool." It follows, therefore, that case work with the aged sick must be as consistently and analytically focused toward gaining an understanding of the meaning of the behavior of the particular patient in response to the effects and demands of his illness as is case work at any age.

Unfortunately, the tendency in medical social case work with aged sick persons has been to protect the patient, planning for him rather than with him: to offer reassurance and supportive service, mobilizing family and community resources on his behalf rather than attempting to enlist his active participation in utilizing to the full extent such capacity as he may have.

There are many justifications for this approach, the reality of which cannot be denied. Chronic illnesses are frequently extremely incapacitating and the majority of patients require protective services to remedy deficiencies in basic subsistence necessities if they are to live at all or to receive even the minimum care afforded by our neglectful communities. So real and so demanding are these needs, and so deficient are our resources and services, that the medical social case worker quite logically and rightly directs her attention to planning that will obtain adequate care for the patient. Her concentration on this area of service is intensified by the usual pressure of the general hospital to release its beds for the acutely ill.

In consequence, medical social work has in a sense developed its own categorical approach to the aged: the approach of protection, palliation and reassurance; and in the achievement of these often difficult ends we have avoided the even more difficult issue of granting to the patient his right to be heard and understood as an individual and his need for some degree of self expression, no matter how great his physical incapacity.

Perhaps this point can best be illustrated by a case situation.

A 65 year old single woman was hospitalized for diabetic gangrene of one leg so severe as to necessitate immediate amputation at the thigh. She had had a mild diabetic condition for several years, which had been entirely controlled by diet; but a month before hospitalization, she had nursed her 85 year old father through pneumonia, managing with no outside assistance except bi-weekly visits from a visiting nurse and the occasional help of neighbors. During this period, she had paid little attention to her diet and had become extremely fatigued. When the gangrenous condition of her leg became apparent she had ignored it until she could no longer bear the pain, as she had not wanted to worry her father.

Since the patient lived alone with her father (a retired railroad engineer) in a two story eight room house, and there were no relatives to assist her at home, the medical social worker and the father agreed that a period of convalescent care in a nursing home would be best, since the patient would require daily dressing of the stump for several weeks and was having to learn to take insulin and to test her urine. The patient acquiesced reluctantly, insisting that she could manage very well at home, on crutches and with a wheel chair, and that her father was fully capable of assisting with the housework and cooking and with her diabetic regime. Both her father and the social worker daily assured her of the merits of the plan for convalescent care in an excellent home which was available in a pleasant suburb and the patient finally was transported there.

Adjustment Was Unsatisfactory

The patient's adjustment in the convalescent home was not satisfactory. Although she had been using crutches before she left the hospital, she refused to use them in the home and could be persuaded to sit up in a wheel chair only with the greatest difficulty. She was unwilling to learn the technic of the diabetic regime and spent much of her time looking out of the window and crying. Whenever her father visited her she wept violently, insisting on going home; and at the end of two weeks he came to the social service department to ask advice.

The worker was much impressed with his vigor, alertness and obvious ability to plan intelligently and resourcefully for the patient's care at home and, despite the warning of her supervisor that the arrangement seemed a hazardous one, she assisted the father in his desire to learn how to give the insulin and to change the dressings, with some help from the visiting nurse.

This patient made a remarkable adjustment in her own house. In less than a month she was carrying out her full household activities, even going up and down stairs on crutches.

The healing of the stump was unusually rapid and her diabetes was so well controlled that the clinician and surgeon concurred in urging the purchase by the social service department of an artificial leg despite her age and the cost of $180. Again the supervisor and director raised questions but finally were convinced by the patient's determination to function at her previous vigorous tempo, her strict adherence to the medical recommendations and her obvious lack of need for any protection or service beyond the purchase of the appliance.

One recognizes, in this patient, unusual capacity for productive living, probably motivated by her affection for her father and a lifetime habit of vigorous physical activity. One may anticipate the threat to her adjustment of her father's ultimate death and of her own lack of financial security but it would seem more than likely that the degree of aggression which she was finally permitted to maintain would afford a more hopeful prognosis for continued independence than if the effort of the social worker had been successful in protecting her through a long period of convalescence which was serving only to promote feelings of depression and insecurity.

Although it is often difficult with the severely handicapped or dangerously ill person to consider the patient's wishes and to help him to accept a practical plan, an area of even greater difficulty for case work service is that of assisting the patient to utilize such limited capacity as he may have to develop constructive and satisfying outlets. Much is being written today concerning the process of growing old gracefully and graciously—which, phrased more crudely, would seem to be an expression of concern for growing old without being a nuisance either to oneself or to others.

Dr. Edward Stieglitz, commenting on the objective of geriatric medicine, says that it "is to add breadth and depth, rather than mere length, to life." He stresses, however, that "more can be accomplished for the aging than for the truly aged. An attitude of prophylaxis during the critical fifth and sixth decades is essential if geriatrics is to assist mankind to realize fully the vast and splendid potentialities of man."[1]

Certainly no one would deny the humanitarian validity of exerting every effort to add breadth and depth to life. This has always been a concern of social workers for clients of any age and to case workers with the aged sick the futility and tragedy of mere prolongation of life have long been apparent. It is, however, one thing to accept the validity of this concept; another to give it reality and meaning for persons impoverished economically and intellectually and still further handicapped by physical restrictions and psychological distress.

Conviction regarding our responsibilities in this area is a first step toward any creative thinking and planning. The case worker who believes in the necessity of adding breadth and depth to the life of a hopelessly incapacitated patient may reach out for and find resources of unexpected richness in the patient himself, his family and in the community. The interest, ingenuity and inspired warmth of feeling which quicken the same responses in others and which tap endlessly at the wellsprings of human philanthropy on behalf of children, the crippled, the blind can find a like response on behalf of the aged sick.

We have today a very few examples of creative planning for the aged in such projects as the Benjamin Rose Institute in Cleveland;[2] the use of friendly visitors from settlement houses and other volunteer organizations; the development of group activities in neighborhood clubs and settlements. The often remarkable effort made by extremely handicapped persons to participate in such groups is a telling indication of the great need for continued and ingenious effort to relieve the loneliness and boredom of the aged and particularly to reach those confined to their homes or to drab institutions for the chronically ill.

Perhaps the most hopeful aspect of this entire problem lies in the possibilities for prevention, not of aging itself but of the negative concomitants of old age. As Dr. Stieglitz and others have pointed out, preparation for old age begins in the fifth and sixth decades of life. To the degree that the individual in middle age achieves maturity in meeting his social and emotional needs and establishes channels for the development of new interests and activities, he may look forward not to frustration, boredom or a sense of no longer having anything to offer in old age but to possibilities for fruitful and satisfying living.

Closely tied in with his adjustment on this basis is its bearing on his state of health, since there is increasing evidence of the relationship between anxiety, defeat or conflict and many of the chronic illnesses of later life. The present focus of both medicine and social work on prevention of social and psychological strains may prove to offer the most hopeful outlook for the future in medical social case work with the aged sick.

[1] Stieglitz, Edward J.: Geriatric Medicine, Preface.

[2] "Modern Old Age," Survey Midmonthly. April 1946.

Administrative Capsules

- Capital funds, budgetary funds and extrabudgetary funds must be brought into balance, with capital funds leading the way to establish the hospital, followed by routine budgetary funds to maintain the hospital and, finally, but concurrently, by sufficient extrabudgetary funds to elevate standards by keeping pace with and improving the educational and research talents of the medical staff.
- There is nothing in the history of medicine which has greater possibilities for good than a strong partnership between science and philanthropy.

Evening Psychiatric Clinic Pioneers in Mental Health

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Director of Clinics, Women and Children's Hospital, Chicago

IN MARCH of this year Women and Children's Hospital, Chicago, launched a new evening psychiatric clinic. It was named the Women and Children's Hospital Mental Hygiene Clinic to describe its primary function and to distinguish it from the regular daytime psychiatric clinic which was an established unit of the outpatient department.

Publicity for this launching was offered but was declined because we wished to proceed slowly, organize carefully and integrate the services we wished to give as wisely as possible. We felt certain that premature publicity would bring a large response in inquiries and applicants before we were ready for it.

On the opening date we thus began to put into effect the previous year's planning which various community agencies, Mrs. Edna H. Nelson, the hospital administrator, the medical staff and the hospital board had contributed to this project. We viewed this event with considerable thrill as we realized the clinic was, in a sense, a pioneer movement.

Gives Service to Patients

It differed from others in that primarily it would give service to patients. This was important because most of the other psychiatric clinical facilities in the city were set up chiefly for teaching and research, with the patients' care necessarily limited to the principal objectives and nature of teaching hospitals and clinics. However, since this was to be essentially a demonstration project, we planned our work, our records and statistics to provide for evaluation and research as to our progress and function in the community.

This clinic was also pioneering in offering services to that large group of upper working class or lower middle income people which was not eligible for the clinical services available to the medically indigent but which, nevertheless, was unable to purchase private psychiatric or psychoanalytic consultation.

The aim and purpose of the clinic can be simply stated. It is:

1. To assist women with mental illnesses or tendencies toward emotional and/or personality disturbances to more acceptable familial, social and vocational adjustments. Its emphasis shall be readjustment and prevention of mental breakdown.

2. To provide outpatient psychiatric care in the evenings for adolescent and adult women who are not able to afford completely private psychiatric care, but who, by virtue of employment or other resources, are in a position to meet semiprivate rates. Women who cannot attend daytime clinics and who are unable to pay any fees will also be accepted on a limited basis.

Historically, the idea for such a clinic was prompted by the committee on health needs of the Council of Social Agencies and the Illinois Society for Mental Hygiene which were concerned with the great problem of the need for psychiatric care and the scarcity of clinical facilities (in this community) to meet this need. In April 1946, Dr. Rudolph G. Novick, medical director, and Iva Aukes, executive assistant of the Illinois Society for Mental Hygiene, interested in our desire to improve our own daytime psychiatric clinic, suggested the need for an evening clinic which might be sponsored by the Community Fund provided it was set up with good standards and personnel.

Then followed the year of planning, of studies of other psychiatric clinics, of consultations with various clinic administrators, of numerous conferences with Dr. Katharine Wright, the chief psychiatrist, the doctors on our own staff, with Alexander Ropchan of the Council of Social Agencies and with Dr. Novick and Miss Aukes, who throughout gave us invaluable advice and guidance for this project.

The administration for this clinic is the same as that of the outpatient department of the hospital and the psychiatrists are members of the psychiatric department of the hospital clinic medical staff. To provide a stimulus for the best standards and practices possible, a group of seven prominent psychiatrists, (Drs. Charlotte Babcock, Francis Gerty, Margaret Girard, Jules Masserman, George Mohr, David Rotman and Irene Sherman), was enlisted to function in an advisory capacity as a clinic committee of the Illinois Society for Mental Hygiene.

The staff is composed of well qualified personnel (all women), consisting of three part time psychiatrists, two part time psychologists, one full time psychiatric social worker and four part time clerical assistants.

Have Varied Backgrounds

Keeping in mind the "Standards for All-Purpose Outpatient Psychiatric Clinics," as compiled by the American Psychiatric Association on professional personnel, our chief psychiatrist was successful in obtaining the interest and assistance of psychiatrists with varied backgrounds of training and interest. We now have on our staff a psychoanalyst, a psychiatrist specializing in neurology and another specialist in psychotherapy. The psychologists and psychiatric social worker have had excellent training and experience; all possess masters' degrees in their field and are contributing a great deal in building a good foundation for this clinic.

The psychologists provide more than just mental testing; they are

equipped to offer personality studies and vocational guidance, thereby enlarging the scope of services offered. The psychiatric social worker, skilled in technics of case work and interviewing, contributes immensely to the program and to the patients. Through her specialized knowledge she is prepared to marshal clinical or other community resources for the patients' welfare. Our psychiatric social worker explains the relationships of the clinic team in this concise fashion.

Each Brings Special Knowledge

"The pattern for mental hygiene clinics has been set in the child guidance clinics. In these, the partnership of three specialists in emotional dynamics has made possible a complete study of the patient as an individual. While a large area of their knowledge is the common ground of psychiatry, psychology and psychiatric social work, each brings to the other a special knowledge. The psychiatrist, as a doctor, has a particular knowledge of bodily reaction to emotional stress; the psychologist is skilled in measuring abilities and aptitudes as well as in discerning through tests the presence of emotional disorders, while the psychiatric social worker, as a representative of the social sciences, brings a background of the social implications of emotional stress."

We are convinced that a new organization needs highly qualified personnel to make a good clinical team; a program is only as strong as the people who work within it. Inasmuch as it was necessary to attract a good staff willing to work regularly two evenings per week, we could not expect volunteer professional services. Even though the rate of payment to the psychiatrists is much below the sum they might reasonably expect to earn in an evening, the salaries of the entire staff and the expenses of psychological and office equipment and supplies required a budget of more than $9500 for the first year.

We planned the fees to vary from $2 to $4 maximum per visit; the rate of payment was to be decided by the workers according to each patient's ability to pay. We estimated that from six to eight patients would be seen each evening. It is easy to see that the income from patient fees could not cover the budget. The actual cost figured at $12.50 per patient visit.

In regard to the clinical facilities necessary for this project, we knew that interviewing rooms with pleasant office atmosphere were needed. Our facilities were already crowded with the equipment and supplies of the cancer prevention center and our rooms, designed primarily as medical examining rooms, presented a strict clinical atmosphere. We were also greatly concerned as to where we might find adequate office space for our full time psychiatric worker.

As we discussed this with our advisers and consultants, the problem seemed almost insurmountable. We felt we were placing our hospital administrator in the same position as that warden of the jail in Canton, Miss., when "Long, long ago, the board of aldermen of Canton adopted the following three resolutions: (1) to build a new jail, (2) to build it out of the materials of the old jail and (3) to use the old jail until the new one is finished." *

We have resolved our problem in almost similar fashion. We built our clinic within the old one. Screens were obtained to soften the appearance of some rooms, an office desk replaced the strictly white medical desk and, fortunately for us, the cancer prevention center had purchased a few new examining tables which have a nice cabinet-like appearance when not in use. Other office equipment, such as a dictating machine for the staff and an additional telephone, had to be supplied.

The response to the clinic on the part of community agencies and the public has been most gratifying. In the first month of operation 32 patients applied. The psychiatric social worker analyzed the problems of the women in this fashion:

"At the outset we expected to deal with the problems of: (1) single girls away from home, lonely, attempting to achieve social or emotional adjustment; (2) single girls at home, either adolescents or older girls, attempting to emancipate themselves from parental jurisdiction; (3) working girls needing to clarify professional goals; (4) unmarried mothers; (5) married women in conflict about marital or maternal problems.

"In addition we have had several referrals of borderline psychotic patients who have been given brief care but not continuing treatment."

As the program gradually becomes known, we are certain the pressures of a slowly accumulating waiting list will indicate the desirability of adding psychiatrists and increasing the staff. This will mean more administrative problems, but until we have to cross that bridge we are inspired by the challenge before us: that of pioneering in the preventive aspect of mental health.

*Survey Midmonthly, May 1947, p. 129.

Washing Surgical Rubber Gloves

TODAY we are all looking for simpler and easier methods of carrying out necessary work and, with this in mind, we developed a formula for washing surgical rubber gloves in the laundry at New York Post-Graduate Medical School and Hospital, New York City.

The gloves are dumped into a pocket of the washer and are given a cold break for five minutes. Soap is added and the temperature is raised to 125°F. The gloves are washed for a period of five minutes and then one hot and one cold rinse are given.

The gloves are then taken out of the washer and put into a dry tumbler for ten minutes at 185° F. after which they are clean and dry. The dry tumbler used has large air volume and low temperature, no recirculated air.

This process has been used for some time and a representative of the glove manufacturer has approved of the method. No unusual wear and tear have been observed. The gloves come out dry without sticking together.

This laundry washing method has proved to be both labor saving and superior to the former process.—LINWOOD MILLER, *laundry foreman, New York Post-Graduate Medical School and Hospital, New York City.*

It's All in a Day's Work

at Misericordia—or any other hospital

SISTER M. FRANCIS de SALES

Formerly at Misericordia Hospital, Philadelphia
Now at Mater Misericordiae, Merion, Pa.

THERE are people and *people* and PEOPLE. And just as it has been said that anything at all *may* happen in a hospital and nearly everything does, so is it true that all kinds of people may come there and nearly every kind does come—every day. They come, almost all of them, under pressure of one kind or another. Few of them are in a normal frame of mind, for if they are not themselves suffering or in trouble, they are interested in someone who is.

Love Begets Sympathy

That, you readily see, is only another way of saying that if most patients, their families and friends are to go away—or to stay—happily, they must be met with tact and patience. If, like Abou ben Adhem, one "loves his fellowman," even in small measure, that is not so difficult. Love begets sympathy and interest; or is it the other way around? Are interest and sympathy the chrysalis from which springs love? However it may be, they are a closely allied trinity which may find full play in any hospital any day. There joy and sorrow, life and death, comedy and tragedy, the commonplace and the sublime are seen in closer intimacy, in sharper contrast, than almost anywhere else. You would have had ample evidence of this, and could have acquired plenty of grist for your literary mill, had you lingered in the proximity of my desk this afternoon.

Shortly after the lunch hour, you would have noted, among others, a starry-eyed young man whose whole personality radiated happiness, asking if he might "see them now," "them" being his newborn daughter and her mother. As he turned away walking on air, I smiled thinking it peculiarly appropriate that his name should be Shinehauer.

The smile died quickly enough, however, at the approach of the next visitor, an older yet not an old man, with iron gray hair and a tired face, from whom the Death Angel had just taken his first born, a beautiful girl of 16 summers, the idol of father, mother and four brothers. Contrasting the bright eyes of the young father with the grief-stricken ones of the older man, it came to me with new vividness how merciful is the Providence that veils the future from men's eyes. Were it otherwise, how often our joy would be tinged with sorrow! How many times sorrow in perspective would be more than we could bear!

The desk is no place to meditate although it presents many subjects for meditation, and my reverie was cut short by the arrival of a hard-featured, belligerent, worried looking woman inquiring for a brother whose life was in the balance upstairs. Her manner was aggressive, her whole being alertly defensive seeming to say: "Don't you dare!" You hardly knew what it was you were not to dare but you knew you better not do it. She reminded me of Hugh Blunt's saying that there are people "who resent dictation even from a sign post."

Yet the bravado was partly assumed, like the cheeriness of the little boy who whistled in the dark to keep from crying. She was really anxious and concerned for the brother who had come from Ireland but six weeks ago. We knew his days were numbered but could not tell her so for it is a very terrible thing to take away the last hope from anyone. When everything possible is being done, one can scarcely be blamed for evading the issue as long as possible and permitting friends to go on hoping against hope.

Two country lads with frank open countenances next presented themselves, smilingly and trustingly asking to see their student nurse sister, who could not restrain her joy as she hastened them off the corridor. A tall, heavily rouged and showily dressed woman stalked past the happy trio demanding why her son, whose discharge is already days overdue, cannot remain three days longer —at the expense of the institution. Awaiting the conclusion of her tirade was one of the gentlest of gentlewomen, one who is no stranger here.

No Thought for Herself

If Lear was every inch a king, she is every inch a lady, a lady in the highest and best sense of that much abused word, and, in addition, I strongly suspect she is a saint also. She always reminds me of Elizabeth of Hungary, the French Queen Blanche and those other women of noble birth who, rich in this world's goods—and in sympathy for their neighbor — were of "the poor in spirit" of whom the Master said: "Theirs is the kingdom of Heaven!" Her dark eyes light up a face whose lines of suffering are softened and sweetened by patience and resignation. She made light of the illness which was to imprison her for weeks to come and spoke only of others whom she felt needed rest and care more than she did, yet were unable to obtain them.

Sickness is no respecter of persons, and the next patient was a beautiful child with hair falling in long black curls, an unusual sight in these days. She was bubbling over with life and happiness, evilently believing that she was returning to the hotel at the shore where she spent the summer for she kept calling for Nora, the maid who attended her there. The mother was as unusual as the child, a modern woman with the ideals of an old fashioned mother, and was in an agony of fear as to the result of the impending operation.

Meanwhile the ambulance had brought in a very sick woman, the mother of seven small children. She was accompanied by her two sisters, one of them pale and delicate looking, the other somewhat more robust. The appearance of both betokened care and thrift, slender means and hard work. They were in tears as they told a story which repeats itself all too often in the midst of our vaunted prosperity.

Couldn't Lose a Day's Wages

The husband had been out of employment for many weeks and only this morning had been given an opportunity to substitute for the day; after his departure, worn out with the struggle to feed and clothe her family, the wife collapsed. The sisters coming in found the mother unconscious, the children hungry, sick and cold, yet would not send for the father lest he lose even the one day's wages.

Although one sister had a family of six and was living on a small and precarious income, she had already taken five of the sick woman's children to her home; the other sister, ill herself, was shouldering the responsibility of the two babies. Could there be greater need? And where, except among God's poor, could you find such ready charity?

The patient was admitted, the two women had gone and I was just finishing the registration of their names, when a child's voice close at hand startled me with: "Is the doctor here that takes fish bones out of your throat?" And there stood a tousled red haired lad of about eight years, no hat, no coat, with an expression of real anxiety on his little freckled face. In his arms he held a kitten wrapped in an embroidered towel, an inquiring nose protruding from the scallops forming an Elizabethan ruff about its tiny black and white face.

"Have you a bone in your throat?" I asked.

"No, but my cat has. Is the doctor that takes bones out here now?"

He was so disturbed and was such an interesting little chap that I decided to give myself the pleasure of going with him to the emergency room. There, with considerable smiling on all our parts, I explained the case to the doctor and supervisor, both of whom were quite willing to help out. We were interrupted by the boy's half pathetic, half indignant voice: "I wish you'd stop talking and *do* something," and he held out the kitten to the doctor. We were properly rebuked and set about "doing something."

While the doctor was fishing for the bone, the boy acted to perfection the part of a solicitous parent; he looked on tensely, making tight little fists and every once in awhile standing on one foot and leaning forward for a better view. He made no sound but expressed anxiety in every gesture. Finally the nurse said:

"What is the kitten's name? We have to put the names of all who come here in this big book."

"Well," hesitatingly, "I don't know what its last name is; its mother's name is Lindy, and its name is Thunder." Then bending over and scrutinizing the kitten more closely, he said, "No, that's Lightning."

"Why did you say that? Why did you say Thunder first, and then change it to Lightning?"

"Because I thought it was. There's two of them; one's Thunder and the other is Lightning, and I thought this was Thunder but it isn't."

He tucked the kitten under his arm, stroking and petting it, still serious and unsmiling, and started out but came back saying: "Where is that towel? I better take it or my Mother'll give me what for!" His emphasis made his meaning perfectly clear, and we could not but laugh again although this time we were careful to be more discreet about it. He was so thoroughly in earnest that the experience was refreshing, seemed to ease the burden of the day and to dispel the shadows of sorrow cast by more tragic cases.

We were still enjoying the boy with the cat when the door opened to admit an Italian laborer holding a not too clean handkerchief to his right eye. To the doctor's query as to what had happened, he replied: "Hurt in the look—sick in the see!" A sufficiently clear if picturesque way of explaining his trouble.

The nurse took up her pen, noted the accident as the thirty-first since morning, and began "What is your name, please?" I bethought me of my neglected desk and hurried upstairs marveling as I went at the number and variety of happenings that crowd themselves into a day's work at Misericordia—or in any hospital.

They Don't Know the Cost

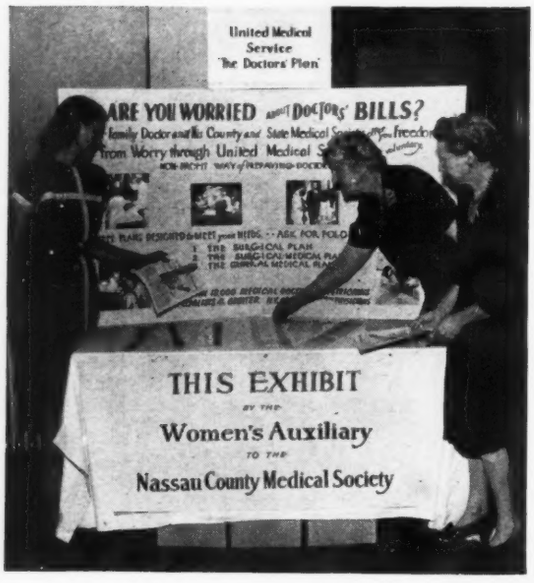
THERE are a great many people, who should know better, who have a feeling that hospitals are growing immensely rich. In fact, two physicians were heard to say in the halls of our own hospital: "Somebody is certainly making a lot of money—the way they charge in this hospital."

Because I am a minister I do considerable speaking around the country and I have been amazed at the ignorance displayed by most laymen as to the real truth about hospital costs. It has been my privilege to enlighten them and many have expressed appreciation, saying: "I did not realize that it cost so much to care for the sick."

I have a feeling that it would be highly profitable to all hospitals and their state and national organizations if we should launch a vigorous campaign of public education on this important subject. I have discovered that when people are properly informed regarding the number of employes required to care for patients and the vast outlay of money required to equip a hospital properly, there is little complaint when it is time for them to pay hospital bills.—REV. H. W. MOHLER, *superintendent, Methodist Hospital, Fort Wayne.*

PEOPLE IN PICTURES

Edward A. Thomson (center), business manager of St. Joseph Hospital, St. Joseph, Mo., is the new president of the Missouri Hospital Association. With him are (l. to r.): Trustee C. J. Hessel, Research Hospital, Kansas City; Martha Rettig, Burge Hospital, Springfield, delegate to the A.H.A.; Mrs. Irene F. McCabe, secretary; Rev. E. C. Hofius, St. Louis, treasurer.



Part of the exhibit of educational material relating to United Medical Service, nonprofit affiliate of Associated Hospital Service of New York, on view at the Mineola Fair in Long Island. The exhibit was sponsored by the woman's auxiliary, Nassau County Medical Society.

Presentation of a plaque honoring Baylor University Hospital as the birthplace of Blue Cross highlighted the Blue Cross banquet in St. Louis. Left to right: John H. Hayes, M. Haskins Coleman, Dr. Justin F. Kimball, founder of the original Baylor plan, and Lawrence Payne.

Convention-chatters: Mrs. Helen B. Ross, administrator, St. Luke's Hospital, Boise, Ida., George U. Wood, Peralta Hospital, Oakland, Calif., new vice president of the A.C.H.A., and Florence King of St. Louis.

Above: Dean Conley, A.C.H.A. secretary, and Homer Wickenden, National Health and Retirement Board.

Right: Pausing for needed refreshment during the convention were A.H.A. staff members: Lynn Wimmer, Anne Saunders and Albert V. Whitehall, of the Washington office.

Public Opinion Supports You

or if not—why not?

GLENN V. RAMSEY
Associate Professor of Psychology
Princeton University
Princeton, N. J.

THE support given by the public to any hospital is largely determined by the opinions and attitudes held by its constituents. Public opinions are merely the forerunners of actions or reactions which can be either favorable or unfavorable. The hospital administrator who desires public support must develop a keen sensitivity to the nature of the opinions in his community. In addition to being aware of current opinions, he must also study them systematically and organize specific programs to develop favorable and rational opinions concerning the hospital and its service program.

Hospitals are being forced to call upon the public for more financial support, the passage of desired legislation, the recruiting of hospital personnel of all types and the acceptance of their programs. The public, in turn, is becoming more sophisticated on matters of care, treatment and services and is demanding that certain standards be met if hospitals expect its support. So, hospitals that seek greater public support must plan to interpret their programs to all members of the community.

Continuous Effort Pays

When opinions have been formed by long term and systematic education of the hospital's place in the community, they will not be swept aside when unfavorable emotionalized events related to hospital service occur. The administrator who waits until he faces some pressing need and then hopes to counteract the resulting harmful opinions will find an almost impossible task before him. However, if the hospital has exerted a continuous effort to interpret its program it will find, when such events arise, that their effects will be less disastrous and will be viewed more objectively.

Many of the traditional opinions and attitudes concerning hospitals held by the public reflect superstitious beliefs, outdated concepts of the hospital's function and misconceptions of care and treatment given patients. It is the hospital's responsibility to keep its public informed as to its true nature and purpose in our society. Don't blame the public for being uninformed and unsympathetic. The hospital should be actively engaged in the dissemination of health information and knowledge of hospital care and treatment and in the replacing of harmful attitudes with good attitudes. The hospital that has discharged such a responsibility has done much to create a cooperative and understanding public.

Let us consider two types of opinion forming mediums, the personal and nonpersonal. The most important medium to hospitals is the personal relationships of its staff with the public. All the nonpersonal types of public interpretation are of only secondary importance in opinion formation when they are compared to the potentialities existing in the medium of personal relationships.

Of these personal relationships the most dependable and promising is the hospital's care and treatment of the patient and his family. It is often forgotten that opinions are more closely related to our emotional experience than they are to our rational thinking. The highly emotionalized experience accompanying hospitalization provides an excellent opportunity for the creation of favorable opinions. It is by such experiences that deep and lasting opinions are formed concerning hospitals.

In a relatively short time, the hospital has an opportunity to reach practically all members of its community in a personal way. In any given year a large proportion of the people in a community will call at the hospital to see a friend or member of the family. In a ten to fifteen year period most of the people of a community will have been patients in a hospital. How the hospital meets the emotional needs of the patient and his family during these visits will, to a large extent, determine the opinions and attitudes they will have concerning the hospital.

Here exists the greatest single opportunity for the hospital to create strong, sound and favorable public opinion. Yet it is precisely in this area that most hospitals have failed to meet the needs of their clients and, consequently, have neglected their richest opportunity to create an understanding and sympathetic public. This point is so important, yet so frequently ignored, that it should be enlarged upon.

Neglects Emotional Aspects

The usual hospital staff member tends to neglect or to be apathetic toward the emotional aspects of illness and hospitalization. Hospitalization is, however, a major and dramatic event in the life of the patient and his family. The psychological effects of hospitalization are usually just as real and often more important to the patient than are the organic aspects of the illness which caused hospitalization. Each individual's emotional reactions are unique and the disturbing effects of these reactions are not necessarily proportional to the severity of the organic illness.

The public seldom attempts to make technical evaluations of surgical-medical treatment, as it is beyond its level of judgment, but people are capable of evaluating the personal care and treatment they receive. How the hospital handles these emotional components of illness has a direct bearing upon atti-

Condensed from a paper presented before the first annual public relations conference of the American Hospital Association, 1947.

tudes and opinions formed by the patient, as well as upon the outcome of treatment. It should be recognized that factors which affect the emotional life of the patient will also affect his entire physical state. The hospital that renders an excellent medical-surgical service and neglects the psychological aspects of illness is not only offering inadequate health services but ignoring the matrix of opinion formation.

The professional atmosphere of a hospital is quickly sensed by the patient and his friends. Physicians and surgeons are, in general, responsible for the nature of the professional attitudes existing in the hospital. The attitude of one doctor toward another, between doctors and nurses and between the staff and patients creates an atmosphere that produces either favorable or unfavorable opinions.

Inappropriate remarks, evidences of personal intimacies between staff members, friction among professional staff members, neglect or careless performance of duty by nonmedical staff members and poor physical care of patients are usually the results of a poor professional attitude created by the medical staff members.

Public Disapproves of Friction

Such breakdowns in professional relationships are noted by patient and family and certainly create nothing but unfavorable opinion. The failure of a hospital to find public support is often the direct result of poor professional attitudes and practices exhibited or tolerated by medical staff members.

Professional staff members should show an interest in the professional problems of the hospital, cooperate with the selected administrative head and give the professional leadership expected of them in the development of the hospital's program. Administrative policies and practices should be well defined. The selected administrative head should be given the responsibility and the authority necessary to execute the stated policies and he should receive the full cooperation of all staff members.

Often it has been said that the nurse is the hospital. This is true because the nurse has in the past had the greatest opportunity to deal with the feelings and attitudes of patients. She has a more personal and continuous relationship with the patient than have other staff members. How she handles emotionalized aspects of illness in her professional work will determine considerably the attitudes and opinions the patients will have toward the hospital. Hospitals that encourage and train their nurses to attend to emotional aspects of illness are rendering more nearly complete service and also are creating deep and favorable attitudes.

The attitudes reflected by all hospital employes in their contacts with patients are of utmost importance. How telephone operators, receptionists, aides, housekeeping personnel, business clerks and other nonprofessional staff members meet and care for the hospital's clients in large measure determines the attitudes that people have about the hospital. The questions and problems presented by patients to such employes should be studied and then more or less standard answers or methods of handling such demands can be established and used by the employes. This would do much to guarantee uniform and acceptable methods of meeting patients' inquiries and demands.

Many hospitals are now adding certain members to their professional staffs who are specialists in caring for emotional and personal problems of patients. Indeed fortunate is the hospital that can obtain the services of a psychiatrist to minister to these needs and to direct such a program. Other professional personnel being added are social workers, clinical psychologists and health educators. They are necessary members of the team of specialists that is needed if adequate care and treatment are to be offered. The utilization of such specialists not only ensures more nearly complete care of patients but also is a means of creating a reservoir of favorable opinion upon which the hospital can rely when in need.

The emotional needs of patients are most acute at time of admission, before operations and during the terminal period of convalescence. It is now recognized that proper attention given to the anxiety and emotional reactions during the admission period will have a direct bearing upon outcomes of treatment. As a by-product, the patient will recognize the quality of such treatment and will be favorably impressed.

Convalescence, which accounts for two thirds of the period of hospitalization, can be a stagnating period or can be used constructively as a period for rehabilitation, education and as a means of accelerating recovery. During the war, army air force hospitals found it medically, psychologically and economically profitable to create separate wards or units for convalescent rehabilitation care and treatment. Civilian hospitals could undoubtedly discover equally satisfying results if they would explore and develop similar programs.

During the convalescent period hospitals can present sound health information, eradicate false and harmful opinions concerning treatment and hospital care and develop individual rehabilitation programs. Here also exists an opportunity for the hospital to inform the public of its services and to explain its needs. The patients who leave the hospital after having acquired a good understanding of its program are likely to become strong and faithful supporters of the institution.

Patients Can Give Suggestions

The hospital administrator can make his staff aware of the importance of the personal aspects of illness by recognizing those who render such service, by calling employes together to discuss this problem and by setting policies that will encourage such attitudes and treatment. A survey of the attitudes and opinions held by patients will give the administrator many valuable suggestions for improving its services to patients. Such a survey can be made by means of personal interviews or by questionnaires.

Standardized individual interviews with each patient during convalescence or just prior to discharge can produce considerable information concerning the patient's opinions and attitudes toward the services received during hospitalization. Studies made during hospitalization will probably produce more data that will be helpful in the improvement of services than will those made from three to six weeks after patients have been discharged. Such studies should be conducted by trained personnel, such as physicians, interns, clinical psychologists, psychiatric nurses or social workers. The interviews should reflect a feeling of

sincere interest in the patient and not have the characteristics of a cold and impersonal survey.

Questionnaire studies administered either during or after hospitalization can also be used to study public opinion. They are more economical than is the interview technic and provide a more nearly standardized method of investigation. Questionnaire studies should at least be supervised by specialists in the measurement of public opinion. The individual who is not skilled in the construction, use and interpretation of questionnaires is likely to introduce many errors into the study.

Other avenues of personal relationship which can be utilized by the hospitals to create favorable opinion are the staff's contacts with service groups, committees and external organizations. The staff of a hospital not only must render excellent service but also must assume the responsibility of interpreting such services to the public. The staff should be willing to discuss with community groups both local and national health problems and how they affect their own community.

Include Laymen on Committees

The inclusion of lay persons on various hospital committees and programs gives the hospital a chance to educate such members thoroughly concerning its program and its needs. Such participation by the public creates a feeling of identity with the hospital and a definite responsibility for its program. If the board of trustees is composed of top-flight representatives of all major elements or groups in the community, then the hospital will have informed leaders in each of these groups who are capable of enlisting broad support for the hospital. The hospital which integrates itself with the community will usually find that the people are willing to give it support.

The various nonpersonal mediums which are available for creating public opinion should also be used. Certainly, a trained public relations director or consultant is a desirable staff member. It is his responsibility to utilize the most effective methods of interpreting the hospital's program. In general, it is better to conduct a long term interpretation program that deals with the basic service of the hospital than to rely upon sudden publicity campaigns which are developed when some special need arises. For instance, the institution that publishes a pamphlet on "How to Use Your Hospital" is conducting a better basic interpretation program than are those hospitals which present only the sensational aspects of accident care.

In the use of radio programs, newspaper articles, pamphlets and other materials, it must be recognized that these releases must compete with those emanating from business and industry. Only specialists in public relations are qualified to develop programs that can meet such competition. Also, those employing such mediums should so construct them that they have an appeal to the average man. In the past, many public relations programs have appealed only to the upper socio-economic groups. Hospitals must broaden their appeal so that all groups will be informed concerning the hospital and its problems.

Clinic Nutrition Project Reports Good Progress

ADELAIDE SPOHN
Elizabeth McCormick Memorial Fund
Chicago

LAURENCE T. ROGERS
Council of Social Agencies
Chicago

"THIS is the most important contribution to clinic nutrition programs in America today," stated one experienced nutritionist in the fall of 1943 when she learned of the plan for enlarging the clinic nutrition programs in the voluntary hospitals of Chicago which have large outpatient services. Now that the demonstration phase has been terminated, an evaluation of the project has been completed. The highlights of the program of the last three years are recorded below as an illustration of community planning for better nutrition education through clinics.

Three agencies were largely responsible for planning, financing and guiding the professional aspects of the project: the Council of Social Agencies of Chicago, the Community Fund of Chicago and the Elizabeth McCormick Memorial Fund.

It is an accepted function of the Council of Social Agencies to plan programs to meet demontrated needs. It is the policy of the Community Fund to finance special projects for the purpose of meeting such needs. The Elizabeth McCormick Memorial Fund has pioneered in the demonstration of ways to meet the health needs of children. It has also promoted and cooperated in efforts to establish and improve nutrition services throughout the Chicago area.

In 1941, at the request of the committee on health needs of the division on health, Chicago Council of Social Agencies, the Elizabeth McCormick Memorial Fund employed a trained nutritionist to make a survey of existing clinic nutrition programs. This survey disclosed a definite lack of nutrition education in clinic programs. The facts established by this review provided the background for planning with hospital authorities an increase of nutrition services on a demonstration basis, with the objective of developing more nearly adequate services. The demonstration was planned on the basis of complete financing by the Community Fund for a three year period.

10 Hospitals Participate

Ten of the 14 voluntary hospital clinics in Chicago requested participation in the project. Of these, six already had some nutrition service by trained nutritionists, but for the others this was an altogether new addition to the program except for limited staff assistance with selected types of therapeutic diets that a few

Services Rendered by Nutritionists, 1944-47

	1944	1945	1946	1947
Total individual visits	35,916	39,520	50,948	59,830
Group meetings per month	110	94	114	174

hospital dietary departments gave their clinics.

A representative advisory committee with responsibility for maintaining and improving the quality of nutrition service was appointed by the division on health of the Council of Social Agencies. This committee has included representation from the medical profession, clinic administration, nutrition, home economics and public welfare.

One interesting feature of the program was the encouragement given to clinics to assume responsibility for teaching the essentials of normal nutrition to clinic patients not diagnosed as needing therapeutic diets. This was a timely contribution to the national nutrition program, which was then gathering momentum as national recognition of the importance of nutrition was further heightened by the findings of Selective Service examinations.

Patients Needed Instruction

Poor food selection and preparation undoubtedly contributed materially to the low level of health which has characterized a large proportion of those in regular clinic attendance. Many physicians were coming to realize that the best medical care provided to a poorly nourished individual was often a waste of time, effort and medicine. Therefore, for financial as well as therapeutic reasons it appeared desirable to instruct clinic patients in the better choice and use of food.

The Elizabeth McCormick Memorial Fund assisted, at the request of the Community Fund, by providing professional supervision to the nutrition workers, both individually and collectively. The leadership provided has been continuous since the project commenced operations in the summer of 1943 and has contributed much to the quality of performance.

Some of the results of supervision and professional leadership, as observed through the three years of project operation, follow: clinics received assistance in the selection of qualified personnel, although the clinic was responsible for the final decision on staff selection; clinic administrators were oriented to the significance of nutrition service and were stimulated to integrate it into the teamwork of the clinic; new employes were encouraged to visit those clinics where the nutrition program was outstanding in one or more particulars.

Regular meetings were held to discuss problems and procedures of common interest. Among the programs, or series of programs, of most interest were those devoted to the preparation and use of visual aids; leaflets for distribution to patients, and the teaching of nutrition to children. A series of meetings was devoted to a study of interviewing technics under the stimulating leadership of Dr. Margaret Mead. The culmination of this study was a dramatic presentation, staged before a meeting of the American Dietetic Association.

This playlet depicted contrasts between the stereotyped nutrition history-taking, which is often a routinized procedure practiced at the first interview, and a first interview by a skilled nutritionist, which does not omit the identification exploration of those clues to personality and motivation that may be of great importance in the success of the nutritionist in changing attitudes and food habits. A series of meetings was devoted to the orientation of nutritionists so they would better appreciate and utilize the skills of their medical social service colleagues.

A study course was conducted by the psychiatrist, Dr. Charlotte G. Babcock, which emphasized the dynamics of human behavior, with special reference to the significance of food in the development of personality and to the continuing psychological significance of food. This course stressed the importance of some understanding of the whole individual in his social setting if good results were to be obtained from the nutrition interview.

Other highlights of the monthly meetings of clinic nutritionists were sessions with Dr. Lydia Roberts, who established one of the first food clinics in the country, and with Dr. W. Franklin Dove of the Food Acceptance Laboratory of the army quartermaster corps, who has introduced scientific methods of determining food preferences as a basis for the solution of army rations. Frequent group conferences were arranged with the director of the home economics division of the Chicago Welfare Department on such questions as extra food allowances for therapeutic diets of patients on relief and quarterly food price samplings, in which the clinic nutritionists assisted, to determine the adequacy of the food allowance for those on relief.

There are at present 18 nutritionists in nongovernmental clinics in Chicago, as compared to six employed by these same clinics prior to July 1943. A few statistics on the services given by nutritionists are shown in the accompanying table.

Aids Medical Management

Evidence which the advisory committee found in evaluation of the project near the end of its third year of operation indicates that there has been a steady growth in the volume of service; that physicians more frequently request assistance from the nutritionist both for clinic and for private patients, and that, according to specific testimony of physicians, the medical management of several categories of patients — diabetics, pediatric and prenatal—has been improved. An expansion of staff in one establishment from one to four nutritionists, three financed by the clinic, has taken place during the period of the demonstration. In many clinics the demand for service is beyond the capacity of the present staff.

The period of 100 per cent Community Fund support for this project ended in 1946. For 1947 this support was scaled down to approximately two thirds of the total cost. The clinics, however, continued without diminution the complete staff of nutritionists as regular clinic personnel. The acceptance by the clinics of responsibility for incorporating the demonstration project as a permanent part of their programs is evidence that the project has sold itself.

SMALL HOSPITAL FORUM

Without a Plan

They May Not Be Prepared for Disaster

Survey shows hospitals have equipment for emergency expansion but lack space and plans for organization of services

MOST hospitals are adequately prepared for disaster emergencies from the standpoint of equipment and supplies, but comparatively few have any organized plan, except in a general way, for disaster service, including assignment of specific duties to staff and personnel, placement of extra beds, procurement of needed materials and services and other points of preparedness emphasized by hospital administrators who have experienced catastrophe demands.

Depends Upon Community Needs

In summary, these are the results of a survey made in a group of hospitals ranging from 50 to 200 beds in size, in all types of community and all sections of the country. Naturally, judgment of whether or not a hospital is adequately prepared for disaster emergency must take into consideration the size, location and nature of the community it serves, with particular reference to concentration of population and existence of industrial and other hazards. Proximity of other hospital facilities is, of course, another important factor.

In the aggregate, the hospitals surveyed have extra beds on hand capable of adding 20 per cent to existing bed capacity. Variation among individual institutions in this aspect of preparedness is great, however; two hospitals reported no extra beds on hand at all, while one, with 200 beds in use, has 150 more in storage.

Plainly, in general the problem is not beds but space to put them in. Of 12 administrators who stated frankly their feeling that they were not adequately prepared for disaster, five named lack of sufficient space as the principal shortcoming. Others included this as one of the inadequacies, and several indicated that there is also a problem that arises from the adaptability of space for hospital use, as well as simple lack of space.

Of 18 hospitals queried as to the location of extra beds to be used in an emergency, 12 have a specific plan showing where such beds are to be placed. The others have no such plan. However, as one administrator stated, "After all, there are only a few places you can put extra beds in most hospitals. First, you double up in rooms and wards, then you use any sun room or waiting-room space there may be, then corridor and, if necessary, lobby space. It depends on the size and severity of the emergency."

About a third of the hospitals reporting keep a cache of supplies (linens, dressings, plasma, drugs and splints) separately stored for disaster use, as distinguished from "ordinary emergencies." Half of the remaining hospitals report the existence of working arrangements with Red Cross, suppliers or other hospitals in the area for immediate delivery of equipment and supplies in case of urgent need. In the group in which no such arrangement or extra inventory is reported, several state that normal supplies are judged sufficient to meet any circumstance that may arise.

Five Have a Plan

Only five hospitals in this group have a disaster organization plan which includes specific assignment of duties to various members of the medical and nursing staffs and hospital personnel. In three of these hospitals, the organization plan is in writing. In addition to the organization and assignment of medical and nursing tasks for the care of disaster victims, the emergency plans in these hospitals include naming certain hospital employes to perform such extra duties as answering personal and telephone inquiries, handling visitors, issuing information, cooperating with the police and the press and meeting other emergency situation requirements.

In the group of 18 hospitals, only two have ever had a disaster drill of any kind, except for drills held once or twice during the war in con-

nection with training then of civilian defense organizations in which hospital and medical groups were an important unit. Opinion on the value of disaster drills is divided; the majority of those expressing themselves on this subject think drills are unnecessary and don't add enough to make the time and effort worth while. A few appear to have a vague feeling that such drills might be a good thing.

On the other hand, an administrator whose hospital not many months ago cared for dozens of the victims of a catastrophic accident said, "It takes a catastrophe to make one fully realize that preparation for disaster has an important place in hospital work. It is my opinion that catastrophe drills should be staged, like fire drills, at least once a year."

The hospitals in this survey were all asked the following question: "Do you consider that your hospital is adequately prepared for any emergency?" One administrator objected to the question as being unfair, pointing out that all do the best they can with what they have to work with, but that few hospitals could ever be ready for "any emergency."

The fact is, however, that five hospitals answered "yes" to the question. Of those that answered "no," lack of space was given as the least satisfactory condition. Others named were lack of equipment, failure to organize staff and employes, lack of written disaster instructions, failure to hold drills, lack of emergency power source and shortage of trained and experienced personnel.

Some of these answers, obviously, were suggested by the survey itself. As one administrator wrote, "It is apparent that we need a disaster program here; I should very much like to see the plans other hospitals are using." Speaking frankly, this administrator was nevertheless expressing the situation that exists in most hospitals, as revealed in this survey.

Three Have Had Experience

Three of the hospitals participating in the forum have had disaster emergencies. In one case, the administrator was satisfied with the performance of his group. In the second case, the care of victims was handicapped by lack of proper space, and in the third hospital, the administrator reported dissatisfaction attributable to the failure to assign specific duties to specific members of the staff, nursing and employe groups.

The importance of area and surrounding population conditions as factors to be considered in emergency preparations is emphasized in contrasting comments from two administrators. One, in a city hospital where traffic emergencies involving several patients are a daily occurrence and disasters bringing dozens of victims by no means a rarity, says that preparations of the kind suggested by the survey are routine. From a smaller hospital in a rural area, on the other hand, comes this observation: "Are you preparing for the day our late allies across the pond find out how to make atomic bombs?"

VOLUNTEER ACTIVITIES

Jobs Are More Technical

"Volunteer jobs are becoming more technical and require more training and supervision," Mrs. Russell Novello, director of volunteer service at Children's Hospital, Boston, points out. "More time per week is needed for these jobs."

At her hospital, Mrs. Novello finds that a more exacting type of service is now required in the expanded outpatient department. "And with the development of wonderful plans for the Medical Center and the progress of medical science, the volunteer will continue to be an esteemed and valuable adjunct to the profession and the hospital," she believes.

Not all jobs require hospital training or are of the year round variety, of course. There is room for short termers. As an example, with the annual advent of polio cases, Children's Hospital needs a girl each afternoon to prepare patients for treatment in the pool. What better place to find such girls than the Bouvé School, a physical education training center in the city. Other colleges and schools also respond to emergency and seasonal demands for helpers.

Why They Aren't Underestimated

Nobody underestimates the power of women at Germantown Dispensary and Hospital, Philadelphia. Its Women's Board has 65 members and Mrs. Leo Nelson Sharpe, its president, reports that at a certain meeting "a veritable fire of enthusiasm burst in our midst and we emerged with authorization to buy a vertical fluoroscope for x-ray examinations of the heart, nine new gas ranges, silver service for Founders Building, furnishings for the reception room and four bedrooms in Main Building, improvements in the supervisors' cottages and a soundproof ceiling in the lecture hall."

That was just one meeting. Proudest of recent achievements has been, in these days of shortages, the acquisition of a new car for the social service department. Two fully equipped operating tables have gone to the surgical department, four steam carts have been provided to bring hot food to ward patients and a substantial contribution has been made to the department of respiratory diseases.

The Cornucopia Shop is one of the Women's Board's chief projects. Open every day it is staffed by volunteers, including Hi-Y girls from Germantown High School. The board now plans to set up a snack bar.

Antedating the Cornucopia Shop and the hospital beauty shop by a quarter of a century is the Benefit Shop where donated clothing, furniture and household items are sold at reasonable prices. From the Benefit Shop proceeds the Women's Board was able to buy the property at 5909 Germantown Avenue and present it to the hospital. A hospital program that receives direct aid from this shop is the occupational therapy department.

All in all there are 21 committees of the Women's Board that assist the hospital in sundry ways.

Miss Emma Earned Her Rest

Miss Emma Hubbell died this year. She was 88. Miss Emma was a great worker in the Ladies Aid Society of Christ Hospital, Cincinnati. She had a reputation to maintain in the sewing circle and in her eighty-ninth year she did not propose to let some young upstart surpass her. There were 3213 articles made by the group in the year and, although Miss Hubbell did not show up at the hospital on the last Tuesday of each month, she sewed in her own home, completing 1629 of the 3213 articles. Pleasant dreams, Miss Emma!

Good Nursing Care Is in the Contract between the patient and the small hospital

HELEN GOODWIN
Superintendent
Rumford Community Hospital
Rumford, Me.

WHEN a hospital admits a patient and accepts the responsibility for treatment, it enters into an implied contract to furnish adequate care. Included in this arrangement, and one of the most important aspects, is the nursing service rendered the patient. The adequacy of the nursing service in a hospital is dependent upon the kind and amount of nursing that the patients receive, and to achieve a really efficient service the hospital must have a thorough belief in the principle of good nursing and must adopt policies and standards which will put that principle into effect.

Putting Policies Into Effect

Once the policies and standards have been set up, how can they be put into effect? This can be accomplished best by saving the time of the nurse, whether graduate or student. To this end, the factors to be considered are: (1) auxiliary or subsidiary workers must relieve the nurse of nonnursing duties; (2) the proper kind and amount of equipment must be available and conveniently placed to carry out nursing activities, and (3) there must be a sound organizational plan that works.

The first means of saving the nurses' time is the employment of auxiliary workers, who may be nurses' helpers, aides, ward clerks, orderlies and maids. The proportion of auxiliary workers to the professional nurses will vary, depending upon the kind of patient cared for in each unit of the hospital or in the hospital generally.

Everyone is familiar with the duties of the nurses' helper, but for those who have not used ward clerks or secretaries, it might be well to list the duties of such persons as follows: cover the admitting desk from 7 to 8:30 a.m.; post temperatures on the clinical sheets; make out intake and output sheets; check the diet slip, adding names of new patients, deleting names of discharged patients and noting change of diets; make daily count of the thermometers and instruments; make out discharge and transfer slips to the office.

The second means of saving the time of professional personnel is to maintain a supply of the proper kind of equipment in sufficient quantity to allow the nurses to carry out their work effectively. It is important that the nurse have what she needs and that she have enough to work with.

A third way to save time is through organization. It is poor economy, in both time and money, to have nurses and other highly paid professional personnel spending a part of their time running errands to the pharmacy, laboratory, admitting office and other points, making up supplies, doing clerical work and many nonprofessional duties made necessary because of bad planning and inefficient organization.

The more nurses are released from duties other than therapy and preventive treatment, the more adequately can they render nursing care.

As to the future of the small hospital training school, I can speak only of our own situation at Rumford Community Hospital, Rumford, Me. It is the desire of the directors to have the school continued, not only from the financial point of view but because of a firm belief that the hospital with a school of nursing can provide a service both to young women in our community who might find it impossible to attend a larger school with higher tuition fees and to those who prefer to remain near home. To be sure, the hospital benefits by having graduate nurses who are willing to remain in the small or rural area.

The medical staff has expressed itself as being in favor of continuing and enlarging the enrollment for the reasons stated. It also prefers students plus some graduate duty nurses to an all-graduate staff, inasmuch as students have, or should have, an attitude of inquiry and cooperation. The physicians like to have students in the hospital, in spite of the fact that some members of the staff are called upon to teach. Although this is time consuming for them, it is beneficial, too.

Challenge to Keep Standards High

From an administrative point of view, while it is difficult to procure and retain properly qualified personnel for the nursing school, there is a definite challenge to keep standards of curriculum, nursing service and nursing care at a high level. At all times, the administrator of the hospital and of the nursing school must be alert to see that the student is not exploited for the benefit of the hospital in providing good nursing care. When this situation does arise, it is the duty of the State Board of Registration of Nurses to have the condition remedied or have the school discontinued.

Now that the national nursing organizations have more time for considering schools of nursing, more pressure will be brought to bear to have fewer schools throughout the country and to have the teaching centered in the larger institutions or in the colleges.

As I see it, if the school has to be discontinued in the small hospital, the only way to carry on with student nurses is to have that hospital provide the larger institution with a rural or small community affiliation.

Read before the Maine Hospital Association, June 1947.

ABOUT PEOPLE

Administrators

Dr. Guy W. Brugler, assistant director of University Hospitals of Cleveland since 1939, has been appointed director of the Children's Hospital of Boston and the proposed $10,000,000 Children's Medical Center, according to **J. W. Farley,** president of the board of trustees. Dr. Brugler succeeds **Dr. Stanton Garfield,** who has been acting director of the institution. During the war Dr. Brugler took a leave of absence from University Hospitals to serve in the army medical corps. He was with the American army's 4th General Hospital in Australia and New Guinea for two years, holding the rank of lieutenant colonel. Subsequently he was executive officer at Woodrow Wilson General Hospital, Staunton, Va., and served with the War Department's special staff in Washington, D. C.

Dr. Brugler is a member of the senior medical advisory group to the Veterans Administration and of the American College of Hospital Administrators.

Arthur Feigenbaum has been advanced from the position of acting superintendent to superintendent of the Jewish Sanitarium and Hospital for Chronic Diseases of Brooklyn, N. Y.

Dr. Frederick W. Hyde Jr. has been named chief resident and director of the outpatient department of Grace Hospital, Detroit, with the title of assistant director of the hospital in charge of these activities, it has been announced by **Dr. Kenneth B. Babcock,** director. At the same time Dr. Babcock announced that **Dr. Frank A. Weiser** will serve as assistant director in charge of education and research.

Joseph W. Erickson is the new administrator of Sanford Hospital, Perryton, Tex. He was formerly business manager of Western Clinic Hospital, Midland, Tex.

Lt. Col. William H. Lee of Reading, Mass., has been appointed administrator of Frisbie Memorial Hospital at Rochester, N. H. He succeeds **Dr. Harry C. Smith,** whose appointment as administrator of Elliott Hospital, Manchester, N. H., was reported last month. Col. Lee was senior administrative officer in charge of army hospitals in England, France and the Far East. He has a background of twenty years in x-ray research work as a physicist, most of it at Massachusetts General and Children's hospitals, Boston.

Rev. Harold W. Mohler, superintendent of Fort Wayne Methodist Hospital, Fort Wayne, Ind., has resigned to reenter the pastorate. He has been appointed pastor of Washington Street Methodist Church, Indianapolis.

E. C. H. Pearson has resigned as superintendent of Good Samaritan Hospital, West Palm Beach, Fla., in order to accept an appointment as head of Salt Lake County General Hospital, Salt Lake City, Utah.

Mary Jane Hutchinson, formerly superintendent, Huntington Hospital, Huntington, L. I., has been appointed administrator of the House of the Holy Comforter, New York City.

Henry Jackson, a former student in the hospital administration course at Northwestern University, has been appointed assistant administrator of Herrick Memorial Hospital, Berkeley, Calif.

Alice E. Snyder, R.N., has been appointed superintendent of the Chicago unit of Shriners' Hospital for Crippled Children, replacing **Helen Young, R.N.,** who resigned recently. Miss Snyder was for six years administrator of St. Luke's Hospital, Marquette, Mich., which is largely devoted to the care of crippled and sick children. She left this post to become head of Geneva General Hospital, Geneva, N. Y., from which she resigned to join the staff of the Shriners' hospitals.

David H. Ross, M.D., assistant director, Mount Sinai Hospital, New York City, has been appointed director of Jewish Hospital, Cincinnati. Prior to joining the staff of Mount Sinai in 1941, Dr. Ross was in public health work, serving first as epidemiologist in training with the New York State Department of Health, and successively as a physician in training at Harvard University, from which he took his degree of master of public health, and assistant district state health officer, New York State Department of Health. He is a member of the American College of Hospital Administrators.

J. L. Thomas Jr. has been appointed superintendent of the Adrian Hospital, Punxsutawney, Pa., succeeding **Col. Louis C. Trimble** who died several weeks ago. Mr. Thomas, a native of Bethlehem, has been manager of motion picture theaters in several Pennsylvania cities and served during the war as a field director for the American Red Cross at Camp Shelby and Keesler Field, Miss.

Mildred H. Shellenberger has been named superintendent of Connellsville State Hospital, Connellsville, Pa., to succeed **Josephine Cope** who resigned several months ago. Miss Shellenberger has been director of nurses at Pottsville Hospital, Pottsville, Pa. She has also served in a similar position at Montefiore Hospital, Pittsburgh.

Department Heads

Mary K. Thomas, R.N., recently medical surgical supervisor at New York Hospital, New York City, has been appointed principal of the school of nursing, Hackensack Hospital, Hackensack, N. J. Miss Thomas succeeds **Marie A. Wooders** who has been principal of the school for the last fourteen years and is leaving to become superintendent of nursing of the Detroit Receiving Hospital, Detroit.

Pearl Sofhay has been appointed occupational therapist at Beth Abraham Home for Incurables, Bronx, N. Y. Previously, Miss Sofhay was associated with Rhoads General Hospital, Utica, N. Y., Mason General Hospital, Brentwood, L. I., and Newington Veterans Hospital, Newington, Conn.

At the same time it was announced that **Beatrice Sivakoff** has been named supervisor of the physical therapy department of the hospital. Miss Sivakoff is a graduate of Hunter College and completed her training at Ashford General Hospital, White Sulphur Springs, W. Va.

C. Jeanette Oswald, formerly educational assistant of the school of nursing of St. Luke's Hospital, Cleveland, has accepted the position of director of nurses at Methodist Hospital School of Nursing, Madison, Wis.

(*Continued on Page* 168.)

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Who Are our *Hospital Leaders?*

MAJOR B. EINSTEIN

RAYMOND P. SLOAN

EVERYBODY was talking hospitals in St. Louis during the week of the American Hospital Association meeting. Taxicab drivers without too much persuasion would describe graphically their recent experiences. At so much as the sight of a convention badge, porters, elevator operators, hotel maids would volunteer their own colorful interpretation of hospital service. And one noontime in the main dining room of the Hotel Jefferson, a hospital trustee, too, talked through the lunch hour and well into the afternoon about hospital work generally —talked until he must excuse himself to attend, believe it or not, a hospital board meeting!

In substance, Major B. Einstein, president of the Jewish Hospital of St. Louis, said this: "The first obligation of the hospital trustee, as I see it, is to provide the highest standards of professional care; second, to assure the maintenance of the physical plant, and, third, to obtain the necessary financing.

"When he is imbued with the proper concepts of health and medical care, he is in a better position to interpret the story to others and to gain financial support. That is to say, to sell others, he himself must first be sold."

Just turned 48, but with only a premature baldness to announce the fact, Mr. Einstein is definitely sold on hospital work, not the work of one hospital alone, but of hospitals generally. His leadership in health and civic affairs has already manifested itself in the records which read to date as follows: president, Jewish Hospital; trustee, Barnard Free Skin and Cancer Hospital; former president, Jewish Federation of St. Louis; former chairman of a committee to determine the basis of allocation of community chest funds to private hospitals for care of indigents sponsored by the United Charities of St. Louis; member of the board of the Social Planning Council; member of the board of directors, St. Louis Chapter of the American Red Cross, and chairman of its larger gifts committee in 1944.

These past assignments Mr. Einstein dismisses with such casual comment as, "Nothing more than anyone would do, or thousands are doing to make their cities and towns better places to live in." Once the conversation gets down to specific problems, however, and particularly hospital problems, new interest can be detected in the Einstein eyes, which while friendly are at the same time extremely keen and analytical. He has only recently assumed the post of president of his hospital, although he has served as board member and vice president for eight or nine years, and hospitals are very much on his mind.

Unlike other prominent laymen who have dedicated a major portion of their lives to hospital work, this hospital president never experienced the slightest desire to adopt medicine as a career. His inclinations were along different lines—engineering to be exact. It was with a degree of chemical engineer that he was graduated from college and, despite the fact that life has since made him a broker, it was the scientific approach that first engaged his interest and support of hospital affairs.

Mr. Einstein received his initiation into hospital operation young. He was still in his thirties when he was elected a member of the board of Jewish Hospital. As was true in most such institutions at the time, the board was large and the average age of its members, higher than it should have been. It may reasonably have been expected that this young recruit would follow the precepts which were established by his predecessors and which had rigidly been adhered to during the years. But not at all. It soon became evi-

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dent that here was a young man with new and challenging ideas.

Precisely why the superintendent or chief executive of a hospital should not be present at board meetings, he could not understand. The more he sought some explanation of this rule, the less he could understand it. Certainly it was contrary to all the principles of sound business organization. And Mr. Einstein recognized that hospital business, in one sense at least, is big business.

The issue became acute. Such an innovation, it was contended by certain die-hards, could scarcely become anything but embarrassing to board members who would feel constrained in discussing hospital affairs before their executive officer, and particularly when that executive officer happened to be a woman.

Young Einstein persevered, however, as is his habit, and despite the remonstrances of his elders who predicted all manner of dire results, Florence King, administrator of Jewish Hospital, was invited to sit in at all board meetings. Today they wonder how they ever got along without her.

Broad View of Health Care

From the year 1938 until 1946, Mr. Einstein served as vice president of the hospital during which period he had an opportunity to make numerous observations. These caused him to reach definite conclusions not only about his own institution but about hospital affairs in general. His activities on another hospital board, representing an institution of entirely different character, also gave him a broader vision of medical and health care.

He had accomplished, he felt, about all he could hope to achieve at Jewish Hospital, for the time being anyway. Its president, although quite advanced in years, evidenced the desire to carry on, which left less opportunity for the younger man to introduce certain of his ideas. So when pressure was brought to bear upon him to head the Jewish Federation of St. Louis, he accepted, notwithstanding that such action made it necessary for him to withdraw from the hospital.

He tells the story in his own frank and unassuming manner.

"One day after several months had elapsed, I received a telephone call from a friend, then a member of the hospital board, informing me that the president felt that he could no longer assume the responsibilities of his post and that a replacement was essential. My friend wanted to know if I would return. I explained that I could scarcely leave the Federation and suggested that he himself take over. He confessed to not being interested in hospital affairs and, in consequence, would not permit his name to be considered under any circumstance.

"After exhausting other possibilities, it was suggested that if the Federation was agreeable, he might take over there for me, thus leaving me free to return to the hospital. This required considerable persuasion but ultimately the 'swap' was effected and I returned as president of Jewish Hospital. So you see," he added, "I am quite green at this business of being hospital president. I have, in fact, much to learn."

Mr. Einstein may have much to learn about hospital affairs, as we all have. After spending several hours talking with him, however, you recognize that his years of association with these institutions, coupled with his broad acquaintance with various types of social agency work, place him in an advantageous position to fulfill the elements of leadership that he has already revealed.

Rising costs, which are as staggering to him as to everyone else involved in hospital work, do not monopolize his thinking and planning completely. Always in his thoughts is the question of whether the hospital—his hospital or any hospital, for that matter—is providing the highest standards of professional care. Mr. Einstein, it may be said, has definite ideas about the responsibility of the board in that regard and its relationship to the medical staff.

Typical of his thinking is the care with which staff appointments are made at Jewish Hospital. First, there is a committee on conference and medical matters which serves as a liaison between the directors and the medical staff. This comprises four trustees with the administrator and the president of the hospital serving ex officio, also the president of the medical staff, two representatives appointed by the medical staff and two additional members of the medical staff appointed by the trustees.

In addition, there is a committee on staff appointments made up of members of the board of trustees who consult with the chiefs of various services for nominations as to both membership and status. This committee takes its recommendations to the committee on conference and medical matters which, in turn, refers its findings to the entire board. Thus, there is no haphazard selection as to who is or who is not eligible to serve. Both trustees and doctors play a definite part in establishing intelligent control.

It all sums up to this, according to Mr. Einstein. "Doctors can be difficult and the board of governors, trustees, call them what you will, must govern with a strong hand, at the same time working closely with the medical staff so that its members may better understand the hospital's problems and the necessity for adhering closely to certain rules and regulations. Most important of all, the board must stand behind its administrator in seeing that all regulations are observed which contribute to higher standards of professional care. Always," and at this point Mr. Einstein speaks with firm conviction, "always professional standards must come first."

An Idealist as Well

We have been talking thus far with the realist, and successful leadership denotes the elements of realism. Now the conversation takes another turn revealing that we are talking as well with an idealist. And who ever heard of a leader who did not possess some measure of idealism?

"Yes, I recognize that there should be less individualism in hospital thinking and planning, that we should work more closely together, hospitals and community health services."

By this time the luncheon table in the Hotel Jefferson dining room had been restored to its custodian who, patient up to a certain point, had long since evidenced signs of petulance over the subject of hospitals and the world in general, and the conversation continued in the comfortable mezzanine lounge.

"We need greater unity, to be sure, but how are we to achieve it? As long as we are of so many faiths, so many different races, and made up of so many different elements,

(*Continued on Page* 118.)

Recent Advances in Anesthesia

and how they affect the surgical department

JOHN S. LUNDY, M.D.
Section on Anesthesiology, Mayo Clinic, Rochester, Minn.

INASMUCH as an anesthetist is a part of the surgical team, any improvement in the effort of the anesthetist ultimately should be reflected in improvement of the effort of the whole team. However, results are not entirely limited to the work done in the operating room but can be traced on into the postoperative period and ultimately they produce in varying degrees some changes in the operation of the hospital itself. For purposes of brevity let us quickly scan developments that cover the period of the last twenty-five years.

In the beginning of this period ether by the open drop method was commonly used and gas machines were being developed. The first notable improvement in this twenty-five year period was the introduction in 1923 of soda lime for absorption of carbon dioxide. Owing to the efforts of Jackson in the laboratory and of Waters in the clinical field the introduction of this procedure made it economically possible to use cyclopropane and greatly to reduce the expense of using the other gases.

Some Prefer Older Technic

Whether or not this procedure has improved the quality of inhalation anesthesia in every instance in which a gas machine is used is not settled. With regard to all gas machines, an attempt was made to utilize the plan of carbon dioxide absorption and it is not clear yet whether this has been accomplished as it should be. There are some who feel that the older technic of administering a high flow of gases with or without ether had much to recommend it and that, although the technic was expensive, it may have been worth the expense involved.

As a matter of fact, in the hands of most anesthetists the use of the so-called gas machine has been so changed because of the soda lime absorber that the procedure today actually consists of the induction of anesthesia with nitrous oxide and oxygen followed by a period in which nitrous oxide, oxygen and ether are given; then anesthesia is maintained almost entirely with ether and oxygen. The results are not much different from those which follow the use of ether by the open drop method. The patient becomes saturated with ether during the operation, he has a prolonged period of recovery of consciousness and he has a prolongation of inebriation, with nausea, vomiting and prostration that is undesirable. This affects the surgeon and his assistants, particularly insofar as water balance is concerned, and a variety of possible complications, such as acute dilatation of the stomach, postoperative pulmonary complications and postoperative damage to the kidneys and liver, may occur.

Fortunately, ether always has been a good anesthetic agent with such a wide margin of safety that the undesirable features of large doses of it as an anesthetic agent are not always obvious to those in attendance but are most revolting to the patient. It is a rarity to find a patient who enjoys this experience. Morbidity as a result of large doses of ether usually leads to mortality in a certain percentage of cases.

I do not infer that the use of soda lime or the plans behind its introduction are to be condemned. On the contrary, the fault is not that of the original plan but rather is due to the fact that the anesthetist tends to produce profound anesthesia and relaxation with large doses of ether, many times without realization of the quantity or concentration of it in the respired atmosphere within the bag. The situation at present need not exist but apparently does exist in a number of institutions to the disadvantage of all concerned.

Use of Ethylene Was Widespread

Spinal anesthesia was not extensively used 25 years ago. Regional anesthesia was hardly used at all and there was no satisfactory anesthetic agent for intravenous use. Rectal anesthesia was being advocated by Gwathmey and others and was not popular. Ethylene had just been introduced and its widespread use was indicative of the desire on the part of many to improve the status of anesthesia which at that time was hardly satisfactory. Because vasomotor collapse occurred rather frequently on the operating table a movement was inititated for recording blood pressure, pulse rate and respiration which, at the time, was revolutionary.

Supportive therapy has been supervised by the anesthetist for some time and has relieved the surgical

Presented at a meeting of the Tri-State Hospital Assembly, Chicago, May 1947.

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3 When injected from individual-dose cartridges, the penicillin in oil and wax suspension should be of slightly thicker consistency. If it is not, and the penicillin settles out, it cannot be resuspended by shaking, because (a) the volume is too small, and (b) the cartridge has no air space.

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department of many tasks. Supervision of oxygen therapy has similarly helped both the surgical department and the hospital services in general.

In 1928 Magill visited this country and spoke on the subject of endotracheal anesthesia and recommended the use of a large bore, soft rubber tube to ensure a good airway. He has greatly advanced the cause of inhalation anesthesia. Through his tube one can aspirate material from the trachea and bronchus, insufflate the lungs in operations on the thorax and the tube can be attached to the gas machine, leaving the field unoccupied by the anesthetist and fully exposed to the surgeon.

This method opened up the field of surgery to many operations that had been performed under too much hazard previously and had a direct effect on the surgical department. It also had a direct effect on the anesthesia department because more skill was required to utilize this technic than was needed for that previously used. Physicians became more interested and more necessary than ever before in the anesthesia department.

Magill Expedited Progress

Many of the subsequent advances in anesthesia owe part of their success to the fact that Magill made his great contribution when he did. The introduction of cyclopropane by Waters in 1933 is an excellent example of the advances which were expedited by Magill's contribution. Respiration is often markedly depressed by cyclopropane; this agent can be administered with increased safety by intermittent compression of the breathing bag by the anesthetist, which is a technic now known as "controlled respiration." Almost ten years after Waters' contribution curare was introduced; its clinical use was made safer by the use of the Magill endotracheal tube.

Intravenous anesthesia was revived by the introduction of hexobarbital soluble (evipan soluble, now evipal soluble) in 1932, and in 1934 sodium ethyl (methylbutyl) thiobarbiturate (pentothal sodium) was introduced and shortly was the principal drug for intravenous anesthesia. In regional and spinal anesthesia the idea of intermittent injections through an indwelling needle was introduced by Lemmon in 1940; his idea was the basis for the use of continuous caudal anesthesia in surgery and obstetrics and for Adams' suggestion that a catheter be substituted for a needle in caudal anesthesia. Tuohy applied the idea of the use of a catheter to spinal anesthesia.

These changes in technic made possible an increased use of the old and safest agent, procaine. In many instances newer agents that had been introduced for the production of long-lasting anesthesia, such as dibucaine (nupercaine hydrochloride) and tetracaine hydrochloride (pontocaine hydrochloride), then became unimportant. The use of prolonged effects from a local anesthetic agent improved considerably the status of the patient in the postoperative period, made for less nursing care and shortened convalescence. The surgical department found its work much easier than before, and the hospital found the turnover of patients to be greatly increased and the burden on the nursing staff to be reduced.

These advances in anesthesia are some of the principal ones. There are others, of course, such as the introduction of tribromethanol (avertin) in 1926. This improved the quality of rectal anesthesia but still did not overcome the dangers of surgical anesthesia resulting from rectal use of anesthetic agents so that even to this day rectal anesthesia cannot be safely carried beyond the point of basal narcosis in any large series of cases without disaster.

Without going into great detail concerning all the agents and methods that have been developed in this twenty-five year period it can now be stated as a fact that the choice of anesthetic agents is sufficiently broad so that no one method of anesthesia is as important as it used to be. The freedom of choice of method permits the anesthetist, for example, to cooperate in the relatively recent effort of surgeons to get their patients out of bed earlier after operation.

Headache which may follow lumbar puncture and which is not infrequently associated with spinal anesthesia might be avoided by use of inhalation anesthesia plus curare which would still provide the relaxation and quiet breathing that are associated with spinal anesthesia. As a matter of fact inhalation anesthesia plus curare can be used in debilitated patients for whom spinal anesthesia is definitely contraindicated.

In 1942 the idea of a postanesthesia observation room was inaugurated. This idea differed definitely from that of the old surgical recovery room in that the patient was sent to this room for reasons associated only with anesthesia in the majority of cases. The room was staffed by persons experienced in caring for patients who were recovering from general anesthesia; adequate equipment and supplies, including oxygen and carbon dioxide, were present to support the patient's pulmonary ventilation; also available were the supplies used in parenteral therapy for support of the patient.

This innovation had a definite effect on the surgical department in that the assistant who went with the patient to this room was able to return immediately to the operating room for the next operation, leaving the intravenous and subcutaneous administration of fluids to the personnel from the anesthesia department. The patient's condition, if it was not satisfactory, could be checked by the physician anesthetist.

Seemed to Increase Costs

This physician then became a standard part of the surgical team and assumed some of the responsibilities previously borne by the surgical team, that is, he was expected to give the patient protection until such time as the patient could be turned over to the care of the surgical team free from the effects of anesthesia. It gave the anesthetist additional responsibility which could not be supplied by a nonmedical person and in many ways it seemed to increase the cost of anesthesia.

Again, this increased cost proved its value in that the patient generally was better anesthetized, that is, he was at least more safely anesthetized, with relaxation being produced with relative safety. Preoperative examination of patients was made with medical judgment and preliminary medication that was suitable was ordered so that it augmented rather than frustrated the efforts of the anesthetist; and the supportive therapy was, in general, managed by the anesthetist and was given from relatively the same medical point of view as though it had been handled by one whose training was definitely surgical. (*Continued on Page* 94.)

In the postoperative period those incidences of morbidity that presented themselves were given medical attention by the anesthetist and in a short time it was shown that postoperative pulmonary complications, and particularly cardiovascular complications, were more satisfactorily handled than ever before.

In general, it appears that the advances in anesthesia are not limited to the introduction of new agents and methods, as important as those contributions are. There has been a marked change as a result of the shifting of responsibilities and activities to a medical level. This is not to say that there have not been good nurse anesthetists. There have been many who have satisfied their surgeons and who have demonstrated real ability in the administration of anesthetic agents. However, even they would not care to be charged with the medical responsibility which is now involved in the administration of the anesthetic agents, the support of the patient and the expediting of operating procedures.

Department Has Changed

The department of anesthesia in large hospitals and in many small ones has changed considerably in respect to the type of personnel employed. Most institutions now require a well trained physician anesthesiologist who will supervise this whole indicated procedure day after day; thus he must surround himself with the best available personnel, hoping that he can give competent coverage twenty-four hours a day and seven days a week; this, in turn, means that increase in personnel, especially in medical personnel, is necessary. All this has a definite effect on the surgical department in that the anesthesia department has become much more expensive and the patient must bear the greater part of the increased burden.

Under these circumstances the hospital administrator who previously had been tempted to support the hospital generally with profits from a less complicated anesthesia department finds himself in the position of preferring to give the patient the advantages of present day facilities and advances in anesthesia with the expectation that a more rapid turnover of patients will tend to cause the income to be increased at least sufficiently to offset the increased cost of the anesthesia department. The financial benefit to the hospital under the old plan for anesthesia is less important, I believe, than are the many benefits that can be exhibited under the new plan, with the many improvements in agents, technics and personnel employed.

NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics, University of Illinois College of Medicine, Chicago 12

Tetra-Ethyl-Ammonium Chloride

A new blocking agent for autonomic ganglia

FOR many years there has been a definite need for a drug capable of diminishing or abolishing sympathetic nervous influences, either by blocking ganglionic transmission or by acting peripherally on the effector cells to prevent the action of epinephrine or sympathin which mediate the effects of adrenergic or sympathetic activity.

Recently, Acheson and Moe, working at Harvard, showed that tetraethyl-ammonium (TEA) has the ability to block the transmission of impulses through autonomic ganglia and, as a consequence, the influence of the sympathetic nervous system is largely abolished. Although parasympathetic effects are also diminished or blocked, this does not obviate the use of the drug in diagnosis and treatment of peripheral vascular disorders.

Chemistry. TEA is a quaternary ammonium compound structurally similar to acetylcholine. A molecule of TEA consists of a nitrogen atom surrounded by four ethyl groups and an ionizable chloride atom. It is hygroscopic, readily soluble in water and stable to heat so that sterile solutions can be prepared without decomposition.

Pharmacology. From extensive pharmacological studies it has been established that TEA is a specific ganglionic blocking agent and the effects produced by the drug are the result of this action. Although the compound is a quaternary derivative of ammonia, it has no curare-like action when used in therapeutic doses in man.

In dogs and cats the intravenous injection of from 3 to 5 mgm./kgm. produces a 50 per cent reduction in mean arterial blood pressure. The pharmacodynamics of the pressor response produced by larger doses have not been worked out. In man doses of from 100 to 500 mgm. of TEA cause a reduction in both systolic and diastolic blood pressures. The change in pressure is manifest in one minute, reaches a maximum in from three to five minutes and gradually returns to normal. This fall is of less magnitude in normotensives than in hypertensives.

Postural hypotension is also induced by TEA. This effect is present from fifteen to sixty minutes after administration, even though resting supine blood pressure has returned to normal.

The decrease of blood pressure is not due to a direct action on vascular musculature. This is indicated by the fact that the intravenous injection causes an increase in blood flow through the femoral artery, but an injection directly into the artery produces no change.

Experiments involving cats, in which the cervical cord has been severed, have proved that the reduction in blood pressure after TEA is not due to anaction on the vasomotor center. In animals so prepared, TEA will not cause further lowering of blood pressure. Yet, if the vasomotor tone is maintained by electrical stim-

ulation of the severed cord, TEA will produce the usual effect. On the other hand, there is no effect on blood pressure maintained by infusion of epinephrine.

The most nearly direct evidence that TEA produces an autonomic blockade by acting on ganglia is furnished by Acheson and Pereira who studied the effect on the superior cervical ganglia of the cat. Their results show that the response of the nictitating membrane to preganglionic stimulation was prevented by TEA, whereas postganglionic stimulation still elicited a response.

Other responses to TEA can also be related, for the most part, to diminished nervous transmission through autonomic ganglia. Such effects as inhibition of gastrointestinal motility, partial or complete loss of tone of the urinary bladder, dilatation of the pupil, loss of accommodation and production of dry mouth are the result of blockade at the parasympathetic ganglia.

The temporary paralysis of the sympathetic ganglia with TEA accounts for the fall in arterial blood pressure, cessation of sweating (if present), ptosis of the upper eyelid and increased vascularity in the extremities as measured by plethysmographic and skin temperature technics.

Little information is available regarding the action of TEA on the human heart. The effect on heart rate is inconstant, the usual result being a slight acceleration. It has been reported that there is a temporary measurable increase in cardiac output regardless of the decreased blood pressure.

TEA increases the work capacity and markedly improves the failing heart, as studied with the aid of the heart-lung preparation. Large doses in intact dogs and cats produce an increase in the amplitude of the T wave in the EKG when the leads are placed comparably to lead I of the human electrocardiogram. Still larger doses produce ventricular extrasystoles and tachycardia; with sufficiently large doses, ventricular fibrillation results.

Subjective effects include an unpleasant metallic taste and a feeling of numbness and coldness in the extremities; the latter occurs immediately after injection but quickly disappears. Somewhat later a tired, relaxed or weak feeling is perceived; this effect is more pronounced with larger doses.

TEA is excreted in the urine. Nearly 50 per cent can be recovered in thirty minutes after the intraveneous injection, and the same amount can be recovered after three hours if the drug is given intramuscularly. Practically all is excreted after twenty-four hours. Since only from 6 to 15 per cent can be found in the urine twenty-four hours after oral ingestion, the drug is destroyed or poorly absorbed in the intestinal tract.

Previous mention was made of the antagonistic action of epinephrine to the depressor effects of TEA. It is perhaps well to note that neostigmine is also capable of reversing the action of TEA. Reardon and co-workers recently reported the ability of prostigmine to restore to activity reflexes which are lost after the administration of the drug; the reflexes studied included those concerned in preventing postural hypotension and those which are involved in accommodation and other pupillary responses. This action of neostigmine has obvious clinical significance, as well as giving further support to the concept that TEA acts chiefly on autonomic ganglia.

Clinical Application. The knowledge that TEA prevents the transmission of impulses through autonomic ganglia suggested the likelihood of its being effective in clinical conditions which are characterized by spasm of the peripheral vascular system resulting from nervous influences.

Coller and co-workers of Michigan reported the use of TEA in patients suffering from causalgia and other related post-traumatic states. They concluded that even though the drug gave sustained relief of pain in 50 per cent of the 20 treated patients for a follow-up period of from two to six months, TEA would not obviate the indications for appropriate sympathectomy. They state that the relief afforded in some of the patients was probably related to physical therapy carried out during the pain-free periods induced by the drug.

The same authors reported the use of TEA in another group of patients suffering from herpes zoster and postherpetic neuralgia. The greatest improvement occurred in those with acute or subacute herpes zoster; the least, in those suffering from postherpetic neuralgia. These facts are in agreement with results achieved with paravertebral block with procaine. As yet, however, an insufficient number of cases has been treated to draw definite conclusions.

In conditions of functional vascular disorders, such as Raynaud's disease, livedo-reticularis and acrocyanosis, TEA has been of little therapeutic value, but it has aided in diagnosis.

In occlusive arterial disease, such as thrombo-angiitis obliterans, the drug has proved useful as an indication as to how the patient would react to appropriate sympathectomy. In addition, pain has been relieved in a number of instances, especially pain experienced while at rest. In these conditions the drug is useful in determining the degree of occlusion in the extremities by utilizing the thermometric and plethysmographic technics to indicate degree of increased vascularity. It has proved of no value in established gangrene.

The use of TEA in peripheral arteriosclerosis obliterans is limited to predicting the benefits of lumbar sympathectomy and controlling nocturnal pain. In thrombophlebitis, it diminishes edema and affords temporary relief of pain.

As mentioned previously, hypertensives react with a marked drop in blood pressure to TEA. Those suffering from nuchal headaches, vertigo, nausea or recent impairment of vision have experienced some relief with the drug.

Attempts have been made to select hypertensives for sympathectomy on the basis of their response to TEA. A definite conclusion is not warranted inasmuch as only a few patients have been studied.

Dosage and Route of Administration. Although the intravenous route has been the one most widely employed, effects of longer duration can be produced by intramuscular injection. The subcutaneous method of administration has been avoided because intense irritation is produced at the site of injection. Orally, the drug is ineffective, even with doses of from 4 to 6 grams. The intravenous dose varies between 100 and 500 mgm.; a 10 per cent solution is the one of choice. If used intramuscularly, the dose should not exceed 20 mgm./kgm. of body weight.

Untoward Reactions With TEA. The usual dose of TEA produces no

alarming reaction in most patients. Occasionally, marked reduction in blood pressure occurs, resulting in nausea, pallor, bradycardia and profuse perspiration. This occurs most frequently in elderly patients and hypertensives. Epinephrine and a moderate Trendelenburg shock position overcome this effect. Even though the blood pressure has returned to the preinjection level after administration of TEA, the patient should be kept in the supine position for some time in order to prevent postural hypotension. Some patients complain of the inability to void and defecate, especially if the intramuscular route is being used.

Effects of extremely large and toxic doses (25 to 50 mgm./kgm., intravenously) include a generalized weakness, nasal congestion, dysarthria and, occasionally, difficult respiration and dysphagia. Complete vasomotor collapse has been reported when using unusually large doses. Fasciculation of muscles also occurs with large intravenous doses and sometimes with those in the therapeutic range. This invariably occurs in the area after intramuscular injection. This effect on muscle following intravenous injection can quite likely be used as an index of overdosage.

At present TEA is only available for clinical investigation under the trade name Etamon (Parke, Davis and Company) but it will soon be approved by the Food and Drug Administration for use by the general practitioner.—C. A. Stone.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

History of Epilepsy

The history of medicine shows that one of the more serious obstacles to progress is the too faithful submission to authority and failure to reason independently from facts observed. This fact is well illustrated by Gordon Holmes in the first Price Lecture on "The Evolution of Clinical Medicine as Illustrated by the History of Epilepsy" (*British Medical Journal*, July 6, 1946), in which he traces the development of our knowledge of epilepsy. Holmes states that he was prompted to select this disease from the many which he could have used by a subsconscious memory of a statement by Oliver Wendell Holmes: "If I wished to show a student the difficulties of getting at truth from clinical experience, I would give him the history of epilepsy to read."

Holmes tells of the early description of epilepsy by Hippocrates and Galen. The observations of these early physicians were neglected for many centuries and during the Dark Ages the concept of epilepsy as a "demon disease" held sway. Sir Thomas Willis in the seventeenth century recognized the fact that the cerebral cortex was the seat of the epileptogenous discharge but our present concept of the pathophysiology of epilepsy is due to Hughlings Jackson. His keen and masterly analysis of all features of epilepsy foreshadowed Berger's discovery of the electroencephalogram.

The history of epilepsy is particularly valuable for the student—and most of us remain students, though perhaps less obective and less receptive to new ideas as age advances—as it shows that one of the most potent obstacles to the advance of knowledge is reliance on authority and subordination to it of accurate observation and analysis in terms of function of the facts observed. —H. Houston Merritt, M.D.)

Periodic Acne!

The ovaries appear to have a definite but variable influence on the condition of the skin. The effect is upon the sebaceous glands, primarily, and a disturbance in this ovariandermal relationship seems to be responsible for the quite common "periodic acne". The skin eruption comes and goes with the menstrual cycle. Periodic headaches may be associated with the condition.

Ovarian Concentrate Armour has been found to be quite beneficial in this syndrome. This preparation is a special sterol fraction, free from demonstrable estrogenic properties, derived from the fat and lipoid fraction of whole ovaries by a special process originated in the Armour Laboratories. It is put up in sealed gelatin capsules (glanules). The recommended dose for periodic acne is one glanule t. i. d. for one month. After this, one glanule t. i. d. for seven to ten days premenstrually may suffice. They should be taken with meals.

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FOOD SERVICE

CONDUCTED BY MARY P. HUDDLESON

How Much Is Enough Food to Buy?

MIRIAM KAUFMAN and GUY H. TRIMBLE

Respectively, Dietary Commodity Analyst and Chief, Equipment and Supply Section
Division of Hospital Facilities, United States Public Health Service

THE economic stress that institutions of all kinds are being called on to endure has aroused a new interest in operating costs. Materials and methods are being studied. Efficiency, once an academic subject dealing with generalities, is now taking on the earmarks of a real problem and has progressed from the stage of pleasant discussion and the theories of efficiency experts to the test of delivering the goods."[1]

This was an opening paragraph of an article published in the *Journal of the American Dietetic Association* in May 1934, 13 years ago. That article dealt with food control in hospitals. In 1934 the purchasing power of the dollar was comparatively high, but the institutions had too few dollars. Today the need for economy is fully as urgent as it was in 1934. Although we now have more dollars to spend, their purchasing power has declined.

The money that goes into salaries for hospital personnel, together with that spent for raw food, accounts for approximately 80 per cent of the hospital's operating budget. About 20 per cent of the total outlay is for raw food alone. Therefore, if economy can be effected in the purchase of raw food, the hospital will realize a definite saving reflected in lower operating costs.

During the war when most food commodities were scarce and food prices were static because of government control, the purchasing of food was largely a matter of finding goods and expediting the delivery of scarce items. Today we should revise our shopping habits. Prices are high. The buyer's market where price quotations could be obtained is gradually returning.

A report of the convention of the American Dietetic Association in Philadelphia will be found on Page 128

However, this obviously is not the time to buy what we do not need, nor is it the time to buy more than we need. To be caught with large inventories of canned goods and other staples while prices are dropping would be poor economy. In purchasing expensive foods, the economy-conscious buyer can often find a good substitute that is just as nutritious as the higher priced commodity.

The hospital that is fortunate enough to have the services of a dietitian usually depends on her to determine its food needs because she is trained and experienced in institutional marketing. However, there is a shortage of dietitians. For that reason table 1 has been prepared. It is offered to the hospital administrator as a guide which he may use to judge the purchasing acumen of his dietary department. To the food manager it will serve as an estimate of how much to buy.

This chart was based on the food needs of a 100 bed general hospital but may be applied to hospitals of varying sizes. It was estimated that approximately 500 meals a day would

(*Continued on Page* 102.)

[1]McAuley, M. Faith: Food Control and the Food Ledger, J.A.D.A., May 1934.

Table 1—Estimated Food Requirements for a 100 Bed General Hospital

FOOD	DAILY PER CAPITA REQUIREMENTS	ESTIMATED REQUIREMENTS FOR 100 BED GENERAL HOSPITAL FOR THREE MONTHS*	REMARKS
MILK Includes powdered, evaporated, buttermilk, cream and whole milk	A pint or more of milk daily	2950-3120 gallons	If properly pasteurized milk is not available, if fresh milk is expensive or if there is a shortage of refrigeration space in the institution, the use of powdered or evaporated milk is often a solution to the problem.**
CHEESE American and cottage	Used to supplement milk and as a meat substitute	225-275 pounds	There are grades of cheese, just as there are of butter, and familiarity with them will serve as a guide in institutional purchasing.***

(*Continued on Page* 101.)

Table I—Estimated Food Requirements for a 100 Bed General Hospital (Cont.)

TOMATOES AND CITRUS FRUITS Canned citrus fruits and juices	At least one serving daily	1425-1600 pounds, canned	Purchase by grade, by size, by suitability to purpose and by season. Purchasing according to weight is an advisable approach. Buying by box, bag, bushel and crate is no guarantee as to yield.
Fresh fruits Includes oranges, lemons, limes, grapefruit		6450-6870 pounds, fresh	
FRUITS, OTHER Canned Includes fruits and juices other than citrus	One to two servings daily of either fresh, frozen, canned or dried	2740-2910 pounds, canned	When buying canned foods, cost of net (drained) weight should be considered. Differences in drained weight may offset wide differences in prices. Sampling goods of various producers will determine best buy.
Fresh Includes apples, berries, cherries, bananas		2825-5020 pounds, fresh	
FRUIT, DRIED Includes, prunes, raisins, apricots, peaches	One to two servings daily of either fresh, canned, frozen or dried fruit	625-675 pounds	Dried fruits are usually more economical for desserts and baking than fresh or canned; however, care should be exercised in quantity purchases since these foods are susceptible to fairly rapid deterioration. Store 32°-50° F. Do not store in damp room.
POTATOES Irish and sweet	Once daily	125-150 bushels	Store potatoes, sweet and Irish, in dark, cool, well ventilated place in slat-bottom bin, temperature 40°-50° F.
LEAFY GREEN AND YELLOW VEGETABLES Fresh as purchased. Includes, green cabbage, lettuce, spinach, squash, turnip tops, kale, green beans	At least one serving daily	3205-4660 pounds	Formulate specifications and purchase accordingly. Example: Designate weight of the container—a hamper of beans may weigh from 24-32 pounds. Initial price may not be the whole story. Too often loss is caused by lack of good storage facilities in hospital.
VEGETABLES, OTHER Canned Fresh as purchased. Includes beets, corn, onions, parsnips, turnips, carrots, radishes, cauliflower	Once daily	2195-2410 pounds, canned 3480-3740 pounds, fresh	The buyer should recognize blemishes that affect quality of vegetable. Good buys can be made when use does not require that the product meet grade requirements in every respect. When buying canned vegetables, it is essential to know grades, varieties, types, counts and sizes that are available.
LEGUMES Dried beans, dried peas, peanuts, peanut butter	Several times a week	345-525 pounds	May be used baked or in soups. Legumes are filling and a good source of protein when meats and eggs are expensive.
EGGS Includes fresh, dried and frozen	At least four to five eggs weekly	1470-1500 dozen	Egg consumption in hospitals is above normal because of high nutritive value and digestibility.
MEAT, FISH, POULTRY Fresh, canned, smoked and frozen. Includes bacon	Serve at least once daily; eggs or cheese may be substituted	9612-10,000 pounds	Low temperature roasting prevents loss through shrinkage. Purchase according to specification. Frozen meat may be a money saver as all waste is removed and only edible portion purchased.
FLOUR AND CEREALS	Whole grain cereal or bread from enriched flour daily	7840-7990 pounds	Generally, the smaller the budget the larger the proportion spent for cereal products as they are nutritious and relatively inexpensive.
BUTTER OR MARGARINE	Serve two or three times daily	1390-1440 pounds	The relatively low price of margarine is a potent argument for its use in institutions.
FATS, OILS	To help satisfy caloric needs	1175-1295 pounds	Hydrogenated fats have better keeping qualities than unhydrogenated. If fat temperatures during cooking are kept below the smoking point, the fat will not decompose so readily and can be used again.
SUGAR AND SIRUPS Including jellies or jams	To help satisfy caloric needs	2975-3100 pounds	Jellies and jams having a pectin base are usually as palatable and much less expensive than those made solely with the whole fruit and sugar. Sugar should be stored in cool DRY place.

*Consumption figures to be valuable should be studied over a period of time. Inasmuch as these figures are to be used also for budgetary estimates, a three month period was used as the basis for study. Of the 550 meals served daily, approximately 295 will be served to personnel and staff.
**See Public Health Bulletin No. 220, Milk Regulation and Code.
***See Federal Specification, C-C-2712.

be served. This estimate was based on a 100 per cent bed occupancy and a ratio of 1.5 persons employed per patient day. Food requirements calculated on the number of persons in the hospital are better criteria for judging food amounts because many hospital employes eat only one or two meals in the institution.

Specifically, the chart is designed to accomplish the following: (1) guide the purchaser in buying, (2) furnish a gross method of checking adequacy of diet, (3) serve as a basis for preparing budget estimates. From the data contained in the chart the food budget in terms of current prices can be determined.

Food buying will vary, even in institutions of similar size and offering a similar type of service. There are several reasons: difference in management and ownership, buying power of the institutions, type of buying organization, receiving and storage facilities and proximity to sources of supply and markets. Variable as these factors are, they do not limit the value of this chart.

Recommended by A.D.A.

The food requirements recommended in this tabulation are in accordance with facts presented by the American Dietetic Association.[1] Allowances have been made for present day increased consumption. These figures were collected over a period of several years from 17 hospitals participating in the survey. The food data collected from these hospitals were arranged in the form of a food ledger and the items were grouped according to similarity of dietetic value to facilitate conversion into a single item.

In order to convert individual food items it was necessary to reduce the items of each group to a common denominator. Fresh fruits, for example, are packaged and purchased by the crate, box, bag, lug, hamper, keg and suitcase lug. It was necessary to convert these heterogeneous units into pounds. One glance at conversion figures required to translate fresh fruits and vegetables into pounds is ample proof of the need for standardization of containers. No attempt was made to add fresh fruit to dried fruit; instead they were recorded separately.

In computing the monthly average for foods that are seasonal, the arithmetical average was used. For

Table 2—Table of Weights and Measures to Aid in Conversion of Units of Commonly Used Food to a Single Basis, the Pound

COMMODITY	UNIT	APPROXIMATE NET WEIGHT OF UNIT IN POUNDS	CONVERSION FACTORS
Apples—fresh	Bushel	48.00	1 lb. dried=7 lb. fresh
Apples—fresh	Box	44.00	
Apples—fresh	Barrel	140.00	1 barrel=3 bushel baskets
Apples—canned	No. 10 can	6.00	
Applesauce—canned	No. 10 can	6.875	
Apricots—fresh	Bushel	48.00	1 lb. dried=5½ lb. fresh
Apricots, Western—fresh	Crate	22.00	
Apricots, canned	No. 10 can	6.75	
Artichokes, globe—fresh	Box	40.00	
Artichokes, Jerusalem—fresh	Bushel	50.00	
Artichokes, hearts—canned	No. 2 can	1.125	
Asparagus—fresh	Crate, 1 doz. 2 pound bunched	24.00	
Asparagus—canned	No. 10 can	6.438	
Avocados—fresh	Box (Calif.)	13.00	
Avocados—fresh	Box (Fla.)	12.00-15.00	
Bananas—fresh	Box	25.00	
Bananas—fresh	Bunch (8 to 9 hand each)	45.00-65.00	
Beans, kidney—canned	No. 10 can	6.75	
Beans, lima—dry	Bushel	56.00	
Beans, lima—fresh	Bushel	32.00	1 lb. shelled=2 lb. unshelled
Beans, other—dry	Bushel	60.00	
Beans, with pork—canned	No. 10 can	6.875	Number No. 10 cans x 2.29 =dry beans
Beans, snap—fresh	Bushel hamper	30.00	
Beets, bunched—fresh	Crate (4 doz. bunched)	57.00	
Beets, without tops—fresh	Crate (6 doz. bunched)	50.00	
Beets, without tops—fresh	Bushel	52.00	
Beets—canned	No. 10 can	6.50	
Blackberries—canned	No. 10 can	6.438	
Blackberries—fresh	Crate (24 qt.)	36.00	
Blueberries—canned	No. 10 can	6.563	
Butter	Tub	63.00	1 lb. butter=21 lb. milk
Cabbage, green—fresh	½ Bushel hamper	50.00	
Cabbage, green—fresh	Crate (Western)	80.00	
Cantaloupes	Crate (Calif.)	60.00	
Carrots, without tops—fresh	Bushel	50.00	
Carrots, bunched—fresh	Crate (6-7 doz. bunched)	60.00	
Carrots—canned	No. 10 can	6.50	
Cauliflower—fresh	½ Bushel crate	37.00	
Celery, bleached—fresh	Crate	45.00	
Cherries, with stems—fresh	Bushel	56.00	1 lb. dried=4-5 lb. fresh
Cherries, without stems—fresh	Bushel	64.00	
Cherries—fresh	Flat box	15.00	
Cherries, R. A.—canned	No. 10 can	6.75	
Cherries, sour pitted—canned	No. 10 can	6.688	
Corn—canned	No. 10 can	6.625	
Corn—fresh	Crate (5-6 doz. ears)	50.00	
Corn, ear, husked—fresh	Bushel	70.00	
Corn oil	Gallon	7.50	
Corn sirup	Gallon	11.50	
Cranberries—fresh	¼ Barrel box	25.00	
Cranberries—fresh	Barrel (approx. 85 qt.)	100.00	
Cranberry sauce—canned	No. 10 can	7.313	
Cream, 30% butterfat	Gallon	8.43	
Cucumbers—fresh	Bushel	48.00	
Dewberries—fresh	Crate (24 qt.)	36.00	
Eggplant—fresh	Crate (1½ bu., 36-60)	48.00	
Eggs, average size	Case (30 doz.)	45.00	1 case=37.5 lb. frozen or liquid and 9.8 lb. dried

(*Continued on Page* 104.)

A Nutrition Handicap Which Must Be Avoided

THE significance of breakfast as an important means of meeting the daily dietary allowances as suggested by the National Research Council was vividly demonstrated in a recent study.† This investigation revealed that subjects who skipped breakfast entirely or who ate a skimpy breakfast failed to receive their daily nutritional requirements in the other two meals of the day. Hence breakfast must be regarded not only as a meal which forestalls morning hunger and fatigue, but also one upon which the organism is closely dependent for its daily share of essential nutrients.

Virtually all nutritionists agree that breakfast should supply from one-fourth to one-third of the daily caloric and nutrient needs. A widely endorsed breakfast pattern, composed of fruit, cereal, milk, bread and butter, aids in organizing a well-rounded morning meal. The cereal serving—consisting of hot or ready-to-eat breakfast cereal, milk and sugar—is a universally recommended component of this breakfast. This serving contributes worth-while amounts of many essential nutrients, including biologically complete proteins, B-complex vitamins, and important minerals.

The quantitative contribution made by 1 ounce of ready-to-eat or hot cereal* (whole grain, enriched, or restored to whole grain values of thiamine, niacin and iron), 4 ounces of milk, and 1 teaspoonful of sugar is indicated by this table.

CALORIES	202	**PHOSPHORUS**	206 mg.
PROTEIN	7.1 Gm.	**IRON**	1.6 mg.
FAT	5.0 Gm.	**THIAMINE**	0.17 mg.
CARBOHYDRATE	33.0 Gm.	**RIBOFLAVIN**	0.24 mg.
CALCIUM	156 mg.	**NIACIN**	1.4 mg.

**Composite average of all breakfast cereals on dry weight basis.*

†Jackson, P., and Schuck, C.: Dietary Habits of Purdue University Women, J. Home Econ. 39:344 (June) 1947.

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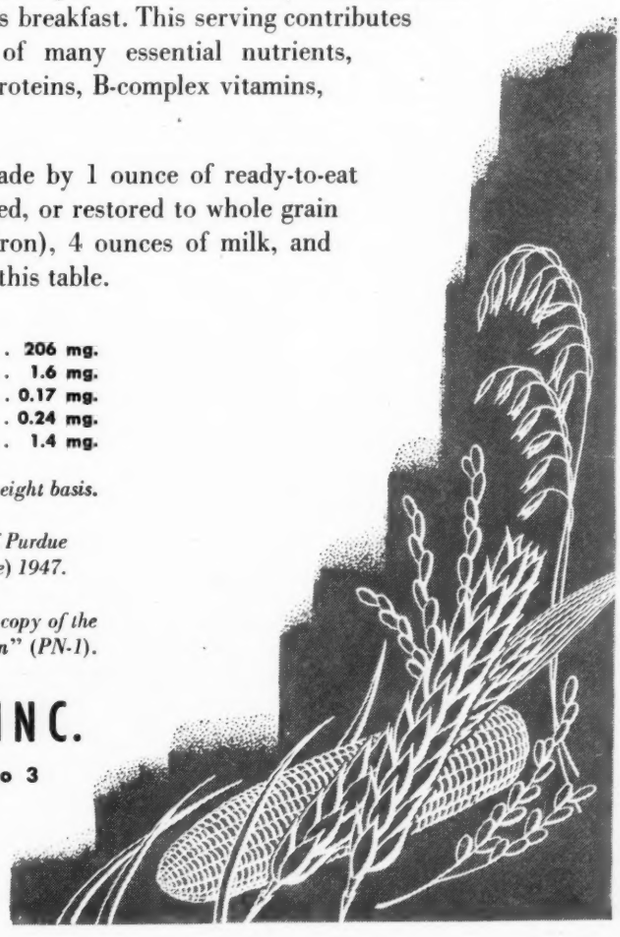

example, if the period studied was six months, and blackberries were purchased only four months, the division was as follows:

$$\frac{\text{Total amt. berries}}{4\ (\text{mo.})} = \text{monthly average}$$

Separate figures on hospital consumption of frozen foods were not available for study, hence are omitted from the table. Miscellaneous groceries are not included because of the difficulty of converting the quantities to a common denominator.

The requirements in the meat, fish and poultry category are the sum of the net weight of canned food in pounds plus the weight of the fresh meats, fish and poultry.

The figures listed in the flour and cereal category are the sum of such items as cereals, prepared and raw, flour of various types, plus the weight in pounds of bakery products, such as cakes and pies, which are produced outside the institution.

Label Weight Used

In any food category in which canned food requirements are given in pounds, the label weight of the can is used to arrive at the figure inasmuch as drained weight figures are not available.

Most of the average weights and conversion figures used are from the U. S. Department of Agriculture Bulletin No. 60 entitled "Approximate Weights of Various Commodities and Other Conversion Factors." Others were taken from an article which appeared in the *Journal of the American Dietetic Association*, July 1942, entitled "Classification of Foods and Factors for Conversion of Their Packaging Units to Pounds" by Col. Paul E. Howe, Lt. Claud S. Pritchett and Lt. George H. Berryman.

Table 2 is a list of conversion figures applicable to the food requirements chart. They will enable the individual hospital to compile a food consumption chart for purposes of comparison.

The Division of Hospital Facilities of the U. S. Public Health Service wishes to thank the following consultants for assistance in the preparation of this article: Marjorie Wood, chief of dietetics service, Hospital Division, U. S. Public Health Service, and Thomas Harrington, food specialist, Veterans Administration, Washington, D. C.

Table 2—Table of Weights and Measures to Aid in Conversion of Units of Commonly Used Food to a Single Basis, the Pound (Cont.)

Figs—fresh	Box, single layer	6.00	1 lb. dried=3-4 lb. fresh
Figs—canned	No. 10 can	7.00	
Flour, various	Barrel	196.00	
Fruit cocktail—canned	No. 10 can	6.75	
Grapefruit—canned	No. 10 can	6.563	
Grapefruit—fresh	Crate (Calif.)	67.00	
Grapefruit—fresh	Crate (Fla.)	80.00	
Grapefruit juice, unsweetened	No. 10 can	6.50	
Grapes—fresh (Eastern)	Lug box	28.00	
Grapes—fresh (Western)	Box, sawdust pack	34.00	
Honey	Gallon	12.00	
Kale—fresh	Bushel	18.00	
Lard	Tierce	375.00	
Lemons—fresh (Calif.)	Crate (pkd.)	75.00	
Lentils—dry	Bushel	60.00	
Lettuce—fresh	Crate (4-6 doz. hd.)	50.00-70.00	
Limes—fresh	Box	80.00	
Maple sirup	Gallon	11.00	1 gal.=8 lb. sugar
Milk—fresh	Gallon	8.60	1 lb. cond. or evap.=2.2 lb. fresh milk
Milk—evaporated	Can (14½ oz.)	.906	No. lbs. dried milk x 8 =lb. fresh milk
Molasses	Gallon	11.75	
Olives: green, ripe, stuffed	No. 10 can	6.844	
Olive oil	Gallon	7.50	
Onions—fresh	Sack	100.00	
Onions—fresh	Sack	50.00	
Onions, green—fresh	Crate (10-15 doz. bun.)	53.00	
Oranges—fresh	Crate (Calif.)	76.00	
Oranges—fresh	Crate (Fla.)	90.00	
Orange juice—canned	No. 10 can	6.50	
Parsnips—fresh	Bushel (bunched)	50.00	
Peaches—fresh	Bushel	48.00	1 lb. dried=5½ lb. fresh
Peaches—fresh	Lug box	20.00	
Peaches—canned	No. 10 can	6.75	
Peanut oil	Gallon	7.50	
Pears—fresh	Bushel	50.00	1 lb. dried=5½ lb. fresh
Pears—fresh	Box	46.00	
Pears, spiced—canned	No. 10 can	6.625	
Peas, green, unshelled—fresh	Bushel	30.00	
Peas—canned	No. 10 can	6.563	
Peppers, green—fresh	Bushel	25.00	
Pineapple—fresh	Crate	70.00	
Pineapple, sliced—canned	No. 10 can	6.75	
Pineapple juice, unsweetened	No. 10 can	6.50	
Plums—fresh	Crate	20.00	
Plums—fresh	Lug (loose)	28.00	
Plums—canned	No. 10 can	6.75	
Potatoes, Irish—fresh	Bushel	60.00	1 lb. dehydrated=4 lb. fresh
Potatoes, Irish—fresh	Barrel	165.00	
Potatoes, sweet—fresh	Bushel	50.00	
Raspberries—fresh	Crate (24 qt.)	36.00	
Rice, milled	Packet or bag	100.00	
Rutabagas—fresh	Bushel	56.00	
Sauerkraut—canned	No. 10 can	6.188	
Spinach—fresh	Bushel	18.00	
Spinach—canned	No. 10 can	6.125	
Strawberries—fresh	Crate (24 qt.)	36.00	
Strawberries—canned	No. 10 can	6.75	
Succotash—canned	No. 10 can	6.75	
Sugarcane sirup	Gallon	11.25	
Tangerines—fresh	½ Strap (Fla.)	40.00	
Tangerines—fresh	Orange box	53.00	
Tomatoes—fresh	Bushel	53.00	
Tomatoes—fresh	Lug	32.00	
Tomatoes—canned	No. 10 can	6.38	
Tomato juice—canned	No. 10 can	6.625	
Turnips, without tops—fresh	Bushel	54.00	
Turnips—fresh	Crate (bunched)	70.00	

Menus for December 1947

Mrs. Paul Arline
King's Daughters' Hospital
Greenville, Miss.

1
Sliced Bananas
Canadian Bacon
•
Cream of Celery Soup
Barbecued Spareribs
Candied Yams
Green Beans
Tomato Aspic Salad
Cornmeal Muffins
Pineapple Upside-Down Cake
•
Cheese Soufflé
Baked Irish Potatoes
Combination Vegetable Salad, French Dressing
Blue Plums
Cookies

2
Tomato Juice
Poached Eggs, Bacon
•
Cream of Mushroom Soup
Roast Beef With Gravy
Parsley Potatoes
Fresh Mustard Greens
Beet and Deviled Egg Salad
Lemon Delicacy
•
Hawaiian Ham Patties
Baked Sweet Potatoes
Head Lettuce With Russian Dressing
Peaches With Whipped Cream

3
Stewed Pears
French Toast, Bacon
•
Consommé
Breaded Veal Cutlets
Escalloped Potatoes
Fresh Green Peas
Carrot and Raisin Salad
Apple Betty
•
Oyster Stew With Oysterettes
Combination Fruit Bowl
Fresh Coconut Cake

4
Half Grapefruit
Scrambled Eggs, Bacon
•
Cream of Carrot Soup
Baked Pork Shoulder With Dressing and Gravy
Cauliflower With Duchess Sauce
Tossed Vegetable Bowl, French Dressing
Lemon Bisque
•
Calf's Liver and Bacon
Baked Grits
Perfection Salad
Daytona Pudding With Raisin Sauce

5
Grapes
Poached Eggs
•
Scotch Broth
Baked Snapper With Green Pea Sauce
Corn Casserole
String Beans
Tomato Salad
Celery Curls
Devil's Food Cake With Custard Sauce
•
Chicken Croquettes With Mushroom Sauce
Parsley Potatoes
Carrot Stripes, Celery, Olives
Prune Pudding

6
Orange Juice
Sausage Links
•
Tomato Bouillon
Roast Beef
Franconia Potatoes
Spinach With Butter Sauce and Lemon Garnish
Fresh Grated Beet and Apple Salad
Coconut Custard
•
Hamburger Balls
Hashed Brown Potatoes
Coleslaw With Boiled Dressing
Gelatin With Whipped Cream

7
Fresh Applesauce
Waffles With Sirup
•
Oxtail Soup
Roast Turkey
Dressing With Giblet Gravy
Green Peas
Cranberry Salad and Celery Curls
Hot Rolls
Mince Pie
•
Cheese Soufflé
Baked Potatoes on Half Shell
Waldorf Salad, Saltines
Layer Cake With Caramel Icing

8
Tangerines
Scrambled Eggs
•
Chicken-Okra Soup
Broiled Steak
Steamed Rice, Milk Gravy
Fresh String Beans
Head Lettuce Salad and Radish Roses
Apple Cobbler, Hard Sauce
•
Egg à la Golden Rod on Toast Points
Asparagus and Beet Salad
Fruit Gelatin With Whipped Cream

9
Prune Juice
Sausage Patties
•
Clam Broth
Pork Chops With Glazed Apple Rings
Sweet Potato Soufflé
Brussels Sprouts With Butter Sauce
Pineapple-Orange-Raisin Salad
Icebox Cookies
•
Cold Cuts
Potato Chips
Tomato and Lettuce Salad
Celery Curls, Olives
Chocolate Cream Pie

10
Fresh Orange Juice
Chipped Beef on Toast
•
Split Pea Soup
Leg of Lamb, Mint Sauce
Mashed Potatoes
Baked Acorn Squash
Vitamin Salad
Apple Pie With Cheese
•
Chicken Turnovers With Gravy
Steamed Rice
Carrot and Apple Salad
Prune Pudding

11
Half Grapefruit
Sausage Links and Grits
•
Cream of Mushroom Soup
Swiss Steak
Parsley Potatoes
Green Beans
Tossed Salad, Thousand Island Dressing
Grapenut Pudding
•
Smothered Chicken
Hot Buttered Grits
Orange and Grapefruit Salad
White Mountain Cake With Chocolate Sauce

12
Kadota Figs
Fried Eggs
•
Vegetable Soup
Salmon Loaf With Tomato Sauce
Whole Kernel Corn
Broccoli With Lemon Sauce
Shredded Cabbage, Green-pepper, Radish Salad
Applesauce Cake
•
Spanish Omelet
Rice
Combination Green Salad
Lime Sherbet

13
Pineapple Juice
Sausage Patties
•
Consommé Julienne
Broiled Lamb Chops
Potato Cakes
Stuffed Squash
Lettuce Salad, Chiffonade Dressing
Apple Cobbler
•
Italian Spaghetti With Meat Balls
Cabbage, Apple, Pineapple and Raisin Salad
Lemon Sponge Pudding

14
Stewed Apricots
Scrambled Eggs
•
Cream of Turkey Soup
Roast Duck With Mint Sauce
Snowball Potatoes
Frozen Peas
Blushing Pear Salad
Orange Mousse
•
Broiled Country Ham
Glazed Sweet Potatoes
Vegetable Aspic
Gingerbread With Whipped Cream

15
Banana Slices
Poached Eggs on Toast
•
Consommé
Southern Fried Chicken
Rice
Green Beans
Succotash
Devil's Food Cake
•
Sausage Patties
Corn Fritters With Sirup
Tomato and Lettuce Salad
Angel Pudding

16
Half Grapefruit
Crisp Bacon and Grits
•
Cream of Celery Soup
Old Fashioned Chicken Pie
String Beans
Stuffed Tomato Salad
Congealed Fruit Compote With Whipped Cream
•
Cold Plate: Salami, Pickle Slices, Potato Chips, Stuffed Celery, Ripe Olives and Open-Face Sweet Sandwiches

17
Tomato Juice
Scrambled Eggs
•
Cream of Mushroom Soup
Ham Loaf With Raisin Sauce
Glazed Carrots
Buttered Spinach
Orange, Grapefruit, Avocado Salad
Indian Pudding
•
Chile Con Carne on Rice Mounds
Head Lettuce With French Dressing
Baked Apples With Fig Stuffing

18
Prunes
French Toast, Bacon
•
Chicken Soup With Rice
Veal Steak
Potatoes au Gratin
Fresh Mustard Greens
Tossed Green Salad With Radish Roses
Pumpkin Pie
•
Tamali Pie
Frozen Peas
Chef's Salad
Strawberry Torte

19
Stewed Figs
Poached Eggs on Toast
•
Beef and Noodle Soup
Fillet of Flounder With Tartare Sauce
Parsley Potatoes
Grilled Tomatoes
Vitamin Salad
Lemon Pie
•
Toasted Cheese Sandwiches
Potato Chips, Celery Curls
Molded Fruit and Nut Salad
Graham Cracker Pudding

20
Applesauce
Sausage Links
•
Cream of Asparagus Soup
Broiled Calf's Liver
Baked Grits
Harvard Beets
Asparagus Salad
Pineapple Milk Sherbet
Cookies
•
Stuffed Frankfurters
Potato Salad
Sliced Tomatoes and Pickle Rings
Pecan Pie

21
Orange Juice
Chipped Beef on Toast
•
Vegetable Soup
Peppers Stuffed With Corn and Minced Bacon
Baked Squash
Fresh Green Lima Beans
Waldorf Salad
Chocolate Layer Cake
•
Baked Ham
French Fried Sweet Potatoes
Peach and Stuffed Prune Salad
Toll House Cookies

22
Stewed Pears
Coffee Cake
•
Consommé
Broiled Chopped Steak With Mushroom Sauce
Baked Potatoes on the Half Shell
Broccoli With Hollandaise Sauce
Molded Carrot Salad
Glorified Rice Pudding
•
Creamed Chicken on Holland Rusk
Baked Grits
Asparagus Salad on Tomato Rings
Prune Cake

23
Kadota Figs
Sausage and Grits
•
Chicken-Noodle Soup
Meat Pie With Biscuit Topping
Green Beans
Steamed Cabbage
Orange-Grapefruit Salad
Mince Pie
•
Spanish Omelet
Southern Lye Hominy
Fruit Salad With Whipped Cream Dressing
Boston Cream Pie

24
Tomato Juice
Griddle Cakes, Sirup
•
Tomato Bouillon
Barbecued Spareribs
Southern Baked Sweet Potatoes
Garden Greens
Tomato and Lettuce Salad
Apple Brown Betty With Whipped Cream
•
Escalloped Potatoes With Hamburgers
Tossed Green Salad
Blue Plums
Icebox Cookies

25
Grapes
Bacon Strips
•
Baked Grapefruit
Split Pea Soup
Roast Turkey With Oyster Dressing
Sweet Potato in Orange Cups
Brussels Sprouts
Cranberry Salad, Celery Curls
Ambrosia
Fruit Cake
•
Tuna Salad
Potato Chips, Celery Curls
Sliced Tomatoes, Olives
Applesauce

26
Baked Apples
Cinnamon Toast
•
Turkey Broth With Rice
Veal Chops
Whipped Potatoes
Green Beans
Shredded Lettuce, Orange, Apple and Raisin Salad
Lemon Chiffon Pie
•
Oyster Soufflé
Baked Potatoes
Head Lettuce With French Dressing
Frozen Peaches on Angel Food Cake

27
Fresh Pineapple Chunkets
Scrambled Eggs
•
Cream of Corn Soup
Meat Loaf With Tomato Sauce
Hashed Brown Potatoes
Grilled Eggplant
Combination Vegetable Salad
Spice Pudding With Foamy Sauce
•
Lamb Chops With Apple Rings
Hot Buttered Grits
Green Peas
Gingerbread With Boiled Custard

28
Half Grapefruit
Sausage Links
•
Tomato Soup
Smothered Chicken
Dressing, Giblet Gravy
Beets With Hollandaise Sauce
Congealed Lime Salad
Chocolate Ice Cream
•
Broiled T-Bone Steak
French Fried Potatoes
Chef's Green Salad
Cherry Tarts

29
Tangerines
Egg and Ham Omelet
•
Vegetable Soup
Swiss Steak
Snowball Potatoes
Fresh Asparagus Tips
Pear Salad
Glorified Fudge Cake
•
Creamed Chipped Beef on Toast Wedges
Green Peas in Potato Nests
Carrot Sticks
Baked Custard

30
Orange Sections
Coddled Eggs
•
Cream of Asparagus Soup
Stuffed Pork Chops
Candied Yams
Garden Greens
Pineapple Salad
Gelatin Whip With Whipped Cream
•
Cheese Omelet
Blueberry Waffles With Sirup

31 Blended Juice, Sausage Patties, Grits • Cream of Celery Soup, Salmon Loaf With Green Pea Sauce, Potatoes au Gratin, Swiss Chard, Tomato Salad With Cucumber Rings, Orange Loaf Cake • Ham Patties, Pineapple Fritters, Jelly, Molded Fruit Cup

(These menus were prepared before the President's food conservation program was announced.)

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PLANT OPERATION & MAINTENANCE

THE FUNCTIONAL BASIS OF HOSPITAL PLANNING

ELECTRICAL SECTION

Continuing a Study by the
Division of Hospital Facilities
United States Public Health Service

THE electrical services should be brought into the building underground when possible, to avoid interruption and unsightly poles. Where available, two services from independent generating plants should be used, one for normal use and the other as a breakdown or emergency service. Should the capacity of one source be limited, it can be used for emergency lights only.

The two services should be tied together with an automatic throw-over switch which will throw all or part of the lights onto the emergency line in case there is an interruption on the first. As a minimum, the emergency service should have sufficient capacity to supply the operating, emergency and delivery rooms, stairs, some corridor lights and exit lights.

When a second outside service is not available, a battery or automatic generator should be used for the emergency lights. In addition to the emergency service, portable lights with batteries and explosion-proof chargers in the bases should be provided for operating rooms. The gasoline or diesel driven generator is preferable in large hospitals, as it is difficult and expensive properly to maintain a large storage battery. Batteries can be used to eliminate light flicker when the generator is starting. A separate transformer should be used for x-ray apparatus.

A three phase, four wire, 120 to 208 volt system of wiring is cheaper than are most systems and has other advantages. With such a system, any lighting panel can be used to supply either three phase or single phase current. Automatic breakers for power and light feeders and for light circuits are more expensive than are fused switches but are far more desirable.

Wire

All feeders and circuits should be installed with high grade wire. There is little difference in cost between code grade wire and that with the better grade insulation, but the life and dependability of the electrical systems depend on the insulation. The minimum requirements for all wiring, conduits and equipment should equal those set by the National Electric Code. As the code does not set any standards for low potential wiring, the specifications should require that all wire be equal to that specified for lighting and that it be installed in rigid conduit to comply with the N.E.C. for 120 volt wiring. High temperature wire is required at many points, as in hoods, on ranges and boilers. Lead sheathed or waterproof wire should be used underground and where condensation may form, as in refrigerator boxes, roof slabs and connections to outside lights. The code should be consulted for special conditions.

Lighting

The lighting of offices, corridors and public and general work spaces can be treated like similar spaces in other buildings, except that a lower intensity can be used. In public and office spaces, the tendency is toward fluorescent lighting as it gives better diffusion and requires less current per candle power. However, the replacement of fluorescent tubes is expensive.

Objections have been raised to using such lighting in spaces accessible to patients because the unnatural color of the skin disturbs some patients. The design of fixtures is not fixed by any special requirements for these areas, so the architect is free to choose or design any fixture that lends itself to the architectural scheme. However, fixtures should be of a functional rather than ornamental design.

Ceiling lights are not recommended for patients' rooms or wards because the glare in patients' eyes is objectionable. When ceiling lights are used in these spaces, they should be so designed that direct rays from the light and bright ceiling spots are not visible to the patients. Lamp standards and adjustable lamps attached to the head of the bed have been used with varying degrees of success; however, they usually shine into the patients' eyes, are subject to breakage, interfere with the free movement of the bed and occupy usable space. New wall-mounted bracket lights are being developed which may overcome these deficiencies.

In addition to the bed light, there should be a duplex convenience outlet at the bed for radio, examination light, heating pads and blankets. Some hospitals use a central radio wired with three channels to each bed, so that the patient may choose one of three broadcasts or recordings. For such reception, special aerials and wiring are required. Aerial outlets at beds are required for portable radios in areas and buildings where reception is poor, but in general the aerial built into the set serves satisfactorily.

There should also be general illumination controlled by a switch at the door. A bracket light over a basin, dresser lights or a lamp standard with a semi-indirect light and reflector will serve. A night light 18 inches from the floor should be provided in

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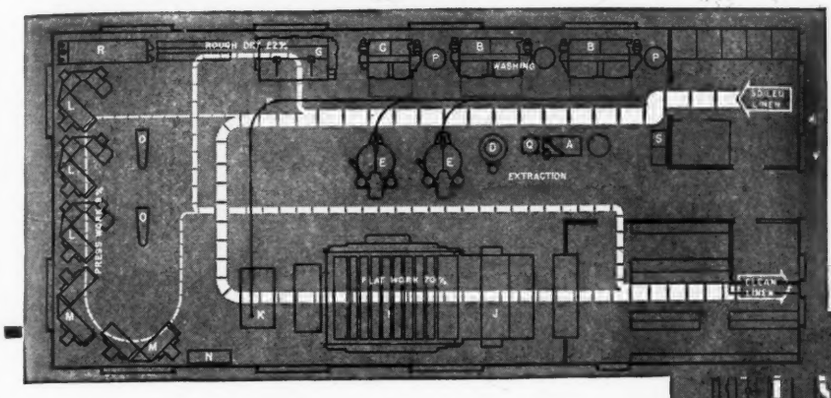

400-Bed General Hospital
(Laundry area: 40'x90')

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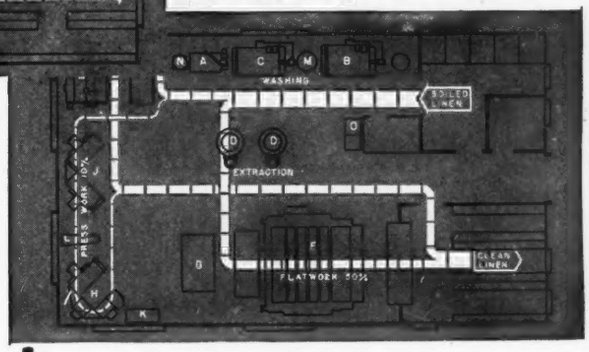
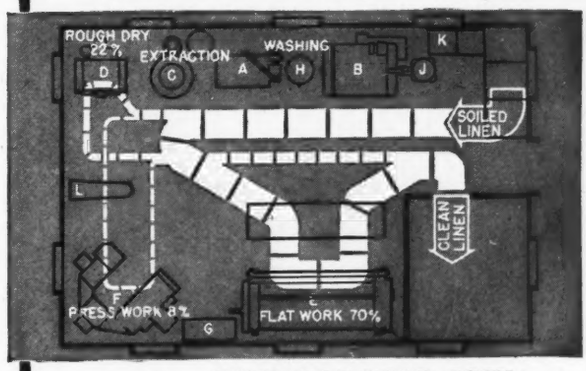
500-Bed Neuro Psychiatric
(Laundry area: 37'x65')

A Hoffman plan for correct flatwork, rough dry and press work capacities as indicated by preliminary study.



50-Bed General Hospital
(Laundry area: 22½'x33½')

Minimum weight handling in a functional arrangement for a small floor space.



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each bedroom and ward, with a switch at the door set well above the room switch. The night light should be mounted at a point that will not be covered by furniture and where it cannot be seen by the patients.

Special convenience outlets in corridors, spaced approximately 40 feet apart, are highly desirable. They should be of the three pole 20 ampere type with one pole grounded for portable x-ray machines, vacuum machines and polishers.

Heavy duty receptacles should also be provided in pantries and utility rooms for hot plates and portable sterilizers. Should electrically heated food carts be used, they will also require heavy duty receptacles in the nursing floor pantries and in the main kitchen. Electric ranges should have three wire feeders with solid connections.

Outlets may be required for illuminated signs in areas where there is much patient or visitor traffic, such as the information desk, cashier's office and outpatient department. Daylight is not used for operating and delivery rooms, so dependable illumination of high intensity is required for these areas. The operating room and delivery room lights should have multiple beams from different angles, focused at the table to penetrate a deep cavity and to prevent shadows. These lights should be mounted to permit lateral and angular adjustment.

Flush ceiling lights with lenses, though more expensive, are preferred by some hospitals. The lights should have two or more filaments or bulbs, preferably on separate circuits as a precaution against light failure. The fixtures should be vaporproof, of a type approved by the National Board of Fire Underwriters. General illumination of these rooms should be of such intensity that there will not be too great a variation in intensity when the surgeon raises his eyes from the operating field. As has been mentioned, the operating and delivery rooms should have lights connected to an emergency source, and portable lights with integral low voltage batteries should be provided. The light panels for operating and delivery rooms should be located in the corridor near the rooms served. Circuits from other rooms should not be connected to this panel.

Exit, stair and corridor lights must conform to local and state codes.

Recommended Hospital Illumination

SPACE TO BE LIGHTED	RECOMMENDED MINIMUM FOOT-CANDLES
Corridors—8 feet	5
Delivery room	
General	50
Supplemental	200
Darkroom, general	10
Emergency treatment	50-100
File room (patients' charts)	25
Kitchens	20
Laboratories	
General	20
Work tables	30
Close work	50
Laundry	
General	15
Pressers and ironers	20
Lavatories	10
Lobby and reception room	10-20
Morgue	
General	20
Necropsy table	200
Nurseries	
General	5
Dressing table (suppl.)	25
Offices	20-30
Operating rooms	
General	50
Operating table (major)	1000
Operating table (minor)	200
Pack room—assembling	15
Pharmacy	30
Private rooms and wards	
General (bracket)	10
Local	30
Sewing room	50
Stairways	6
Sterilizing rooms	10
Supply rooms	
General	10
Record desk	20
X-ray rooms	15

Explosion Hazards

The receptacles and switches in operating, delivery and anesthesia rooms should be of the three pole explosion-proof type with one pole grounded, and all motors and electrical equipment must be explosion-proof, properly grounded to comply with the national and local codes. Viewing cabinets for films should be explosion-proof or be sealed gas-tight on the operating room side with access for changing bulbs from the corridor only.

The use of approved explosion-proof electrical equipment will prevent explosions that might be caused by arcs at the lighting equipment. Special consideration must also be given to the prevention of explosions caused by sparks from static charges that may be generated in the room. The most effective preventive measures are the grounding of floors and high humidity. The old methods of grounding which employed grounded grids of brass strips, grounded tiles, chains and cement terrazzo are not considered adequate. The flooring should be of conductive material having a continuous conductive surface with no insulated spots on which a foot, table leg or equipment can rest.

The recommendations of the National Fire Protection Association should be followed, approved conductive materials being used. The flooring material should have a high resistance which will permit the flow of static current but will prevent the flow of current of a high amperage. This resistance then protects the doctors and nurses against shock from the lighting system and eliminates arcs which might be caused by a live wire coming in contact with the floor. The effect of high humidity in the prevention of static sparks is considered under "Ventilation."

Rubber or nonconductive soles on shoes, rubber tips on furniture legs and insulated supports for other equipment cannot be safely used unless electrically conductive rubber or other conductive material is employed.

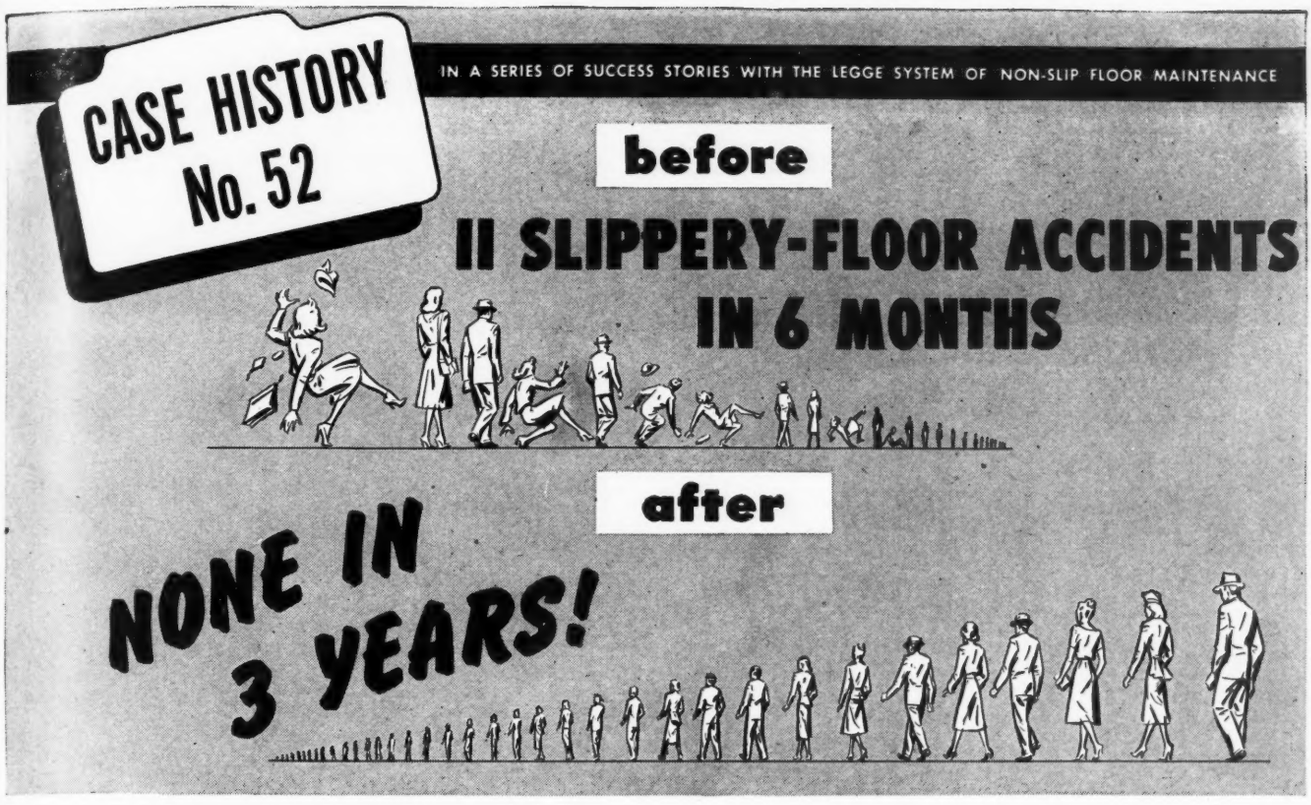
Switches

Silent mercury switches are recommended throughout the patients' floors to reduce noises which would disturb patients. If silent switches are not used, the night light switches should be mounted in the corridor. Night light switches should be mounted 5 feet 6 inches from the floor to distinguish them from other switches. When possible, switches should be used in place of pull cords to reduce maintenance. Automatic door switches are recommended for small closets.

Call Systems

Electrical call systems should be provided in all hospitals so that the patients may receive prompt service and the nurses, doctors and attendants may operate more efficiently. The most important systems are the nurses' call, doctors' paging and doctors' in-and-out.

THE NURSES' CALL SYSTEM consists of a station at each bed, or one dual station for two beds, which the patient can use to call the nurse. These stations are of two types, the pull-cord and the push-button. The pull-cord station consists of a tumbler switch mounted in the wall above the bed which can be operated by a cord. One objection to this type has been that the noise of the switch may disturb another patient in the room



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or in an adjoining room. This noise can be eliminated by the use of mercury toggle switches. The main advantage of this type of station is that it is cheaper and can be operated by the 110 volt lighting system and with neon-glow signal lamps.

The push-button station consists of a pear type of push button connected with a rubber insulated cord to "disconnects" in the wall. Both types should be arranged so the call can be turned off by the nurse at the bed when she answers the signal. When there are more than two call stations in a room, each should have a pilot to indicate which patient has called.

Push-button calls for patients' baths and toilets are desirable. The calls should be connected to operate signal lights over the patients' room door, at the nurses' station and in the floor pantry and utility rooms. Each of these stations should have an audible signal which sounds when the call is made. Two or more lights at the nurses' station, to indicate the section of the floor from which the call came, are at times desirable.

For private rooms and when private nurses are employed, an annunciator should be used at the nurses' station instead of lights. For private room service an annunciator should also be used in the nurses' restroom on the floor. Supervisory recorders or annunciators for the superintendent of nurses have been used, but these are not recommended.

A more expensive system for nurses' calls which is being given favorable consideration is the intercommunicating type with a microphone and loud-speaker at the bed. The patient can ring for the nurse or speak to her and receive an answer. By leaving the patient's microphone open, the nurse can check on the movements of the patient without leaving her desk. In addition to the higher first cost, maintenance and replacement of the microphone system are more expensive than for the simple system, but it can save many nurses' steps.

THE DOCTORS' PAGING SYSTEM may consist of loud-speakers located throughout the hospital, chimes on which doctors' numbers can be sounded or the flasher type which indicates the doctors' numbers. The loud-speaker and other audible calls are objectionable as they may disturb the patients and attendants. The

flasher system consists of a key board and flasher at the telephone switchboard. The telephone operator can set the board to flash as many as three doctors' numbers automatically in rotation. The numbers appear on annunciators located in all sections of the corridors. The same number of numerals, usually three, should be used for each doctor so that a burned out lamp can be located.

These paging systems should also be used for calling interns, administrators, heads of departments and their assistants, and engineers. These flashers can also be used for other general calls such as "fire" with a red "F" and buzzer. The flasher call system has its shortcomings as the individual may fail to see his numbers when flashed. For this reason the flasher system is sometimes supplemented with loud-speakers at points where interns, department heads and doctors may congregate, *i.e.* in the doctors' lounge, staff dining room, laboratory and engineer's office, where the calls will not disturb the patients.

The radio call promises to overcome all these objections. This system consists of a low powered sending station from which calls are broadcast throughout the hospital to miniature receiving sets which the doctors and others can carry in their pockets. This system has been developed but has not yet been placed on the market.

THE DOCTORS' IN-AND-OUT SYSTEM serves a useful purpose as it permits the doctors to register "in" and "out" with minimum effort and without delay. The system consists of a board at the doctors' entrance on which all doctors are listed, with a toggle switch at each name. Each doctor on entering turns on his switch, which indicates on an annunciator at the telephone switchboard that the doctor is "in." When leaving, the doctor registers "out" by turning off his switch. The doctors' "in" and "out" switches can be located at more than one entrance by using three-way switches. These boards can be provided with a red light at each doctor's name to show when he is "in" and the same light can be connected with a switch and flasher at the switchboard to indicate to the doctor as he enters or leaves that he is wanted.

CALL-BACK SYSTEMS are used for nurses' and interns' bedrooms. With such systems the nurses and interns can be awakened, called for duty or called to the telephone by push buttons in the office which operate buzzers in the rooms. The room called can answer by pushing a button which registers on an annunciator in the office. The main office pushes can be connected so that several rooms or sections can be called by one button.

Telephones

Interconnecting telephones should be provided for all department heads, assistants, operating and delivery rooms, nurses' stations, offices, housekeeper, doctors' rooms, record rooms and diet kitchens. These can be connected on a dial system which will permit interior communication without calling the hospital switchboard. At all private and semiprivate beds, telephone jacks should be installed so that a telephone can be plugged in at any time with a minimum rental charge to the hospital.

Rigid conduit should be provided for all wiring to all instruments. An empty conduit should be left for instruments which might be required at a future date. This arrangement has proved to be the most efficient and entirely satisfactory.

Public pay stations should be provided at convenient points for visitors and hospital personnel.

Intercommunication

Telautograph systems which transmit written messages from one department to another are being used successfully by some large hospitals. These systems have the advantage of leaving a written record of the message at the receiving station. The electrical wiring is installed by the hospital and the instruments are furnished to the hospital on a rental basis. The first cost and rental charges are relatively high, which accounts for the limited use of these systems.

Audible speaker systems with microphones and loud-speakers are being used with success for commu-

nication between the superintendent and department heads.

Pneumatic tube systems are extremely useful for carrying records, prescriptions and orders from one department to another. The simplest form consists of tubes through which carriers are dropped from the upper to lower floor stations and returned in baskets. Such a system can be used to furnish the business office with records of charges or to send prescriptions to the pharmacy, when these departments are located directly below the sending station. Pneumatic tube systems are adapted to more general use, but their design and operations are more complicated and they are not justified for a small hospital. These systems are operated by a vacuum in the tubes to move the carriers from one position to another.

Fire Alarms

When state and city codes require fire alarm systems, these should be followed, and in other localities equipment approved by the National Board of Fire Underwriters should be used. In all cases, the system should be of the closed circuit, electrically supervised, break-glass, code ringing type, so connected that in case of trouble with wiring or the current supply a gong will sound at a location where it can be heard at all times.

Some codes require that alarm gongs be located in patients' corridors, but many hospitals object to these locations as they tend to cause panic and false alarms disturb the patients unnecessarily. When such locations are designated by code, a presignal system can often be used to notify all nurses, superintendent, engineer, elevator operator, telephone operator and all offices when the alarm is turned in. Then, should the fire be serious, the second or general alarm can be sounded. When it is not required, the general alarm feature is omitted and all nurses and hospital personnel receive the first alarm. A silent alarm can then be flashed to all sections of the hospital with the doctors' call system by using an annunciator with a red "F" and buzzer.

Clocks

Electrical clock systems should be provided, with clocks at nurses' stations, telephone switchboard, in main lobby, kitchen, laundry, dining room and boiler room, as well as in the operating and delivery rooms. The clocks should be of the recessed type, preferably with a narrow frame. In the operating and delivery rooms, an additional clock with separate minute and second hands which can be started, stopped and reset is desirable.

Special Installations

Short wave, ultraviolet ray or sterile ray lamps have been used in some hospitals to reduce the bacteria count in certain areas. They have been used in the ceilings of operating and delivery rooms and around the operating room light. They are also used in nurseries, so arranged that the rays cannot fall on the babies or shine into the nurses' eyes.

The lamps have also been used to form a curtain of ultraviolet rays of high intensity to prevent the passage of bacteria from one area to another. To be effective a constant intensity of the rays must be maintained, particularly in operating rooms, as too high an intensity will affect the skin of the surgeon and the rays will be

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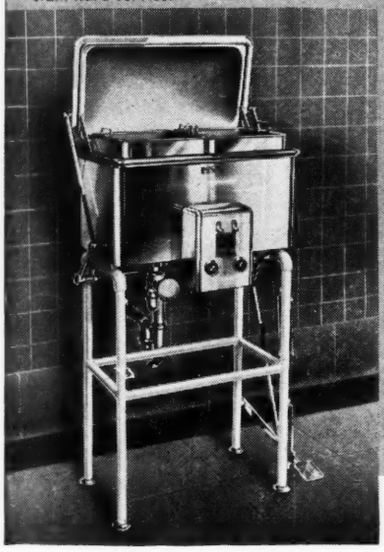

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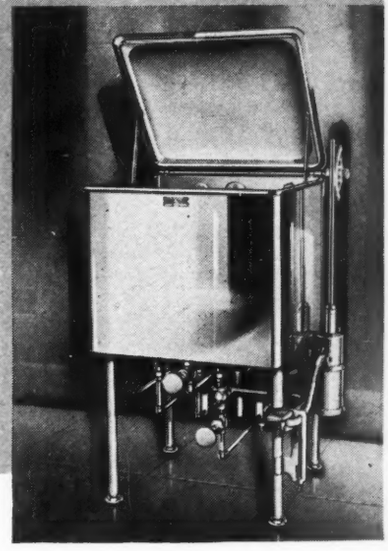

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ineffective if the intensity is too low. These lamps are also used in ventilating systems, particularly where air is recirculated, and in virus and bacteriological laboratories as a protection for technicians.

Special wiring must be provided for the x-ray, electrotherapy, diathermy, electrocardiography and electronic fever equipment, sterilizers and heated food carts. The wiring requirements should be obtained from the manufacturer as they are not the same for all makes.

The heating, ventilating, plumbing, refrigeration and kitchen engineers must also be consulted to determine the wiring required by them for motors, automatic controls, dampers, sterilizers and kitchen equipment.

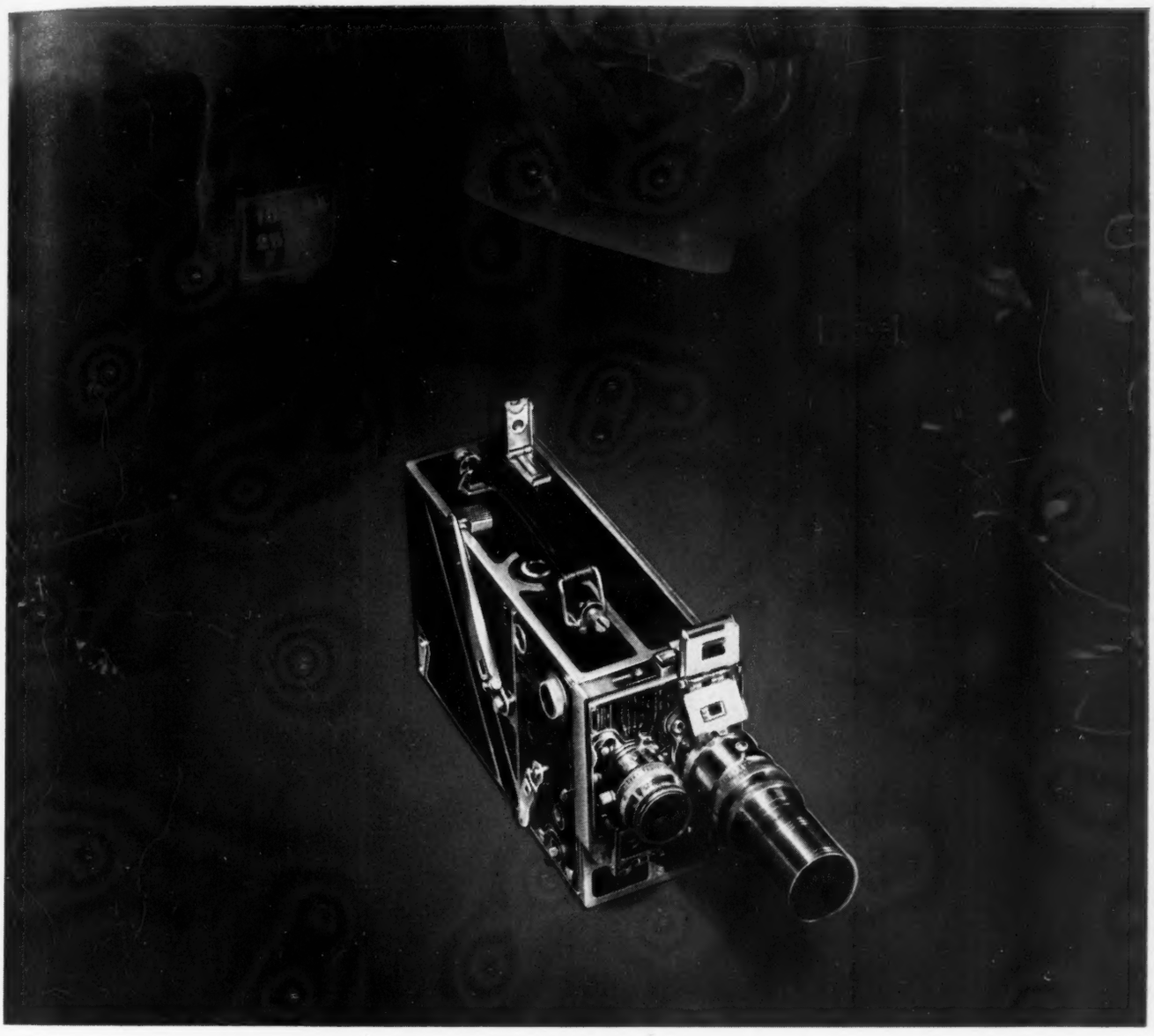
Tests and Inspections

After all wiring, switchboards, fixtures and equipment are in place, they should be checked carefully together and separately with a megger to determine the resistance in ohms of the insulation. The resistance should in all cases be equal to or higher than that recommended by the National Electric Code.

Continual testing and inspection of all electrical installations are essential. Even a brief lighting failure may cause annoyance and apprehension and interfere with proper care. Needless to say, failures of operating room lights or equipment, therapeutic equipment or other installations may have extremely serious consequences and no effort should be spared to prevent them.

Instructions

All panel boards and switchboards should have diagrams under glass to indicate the equipment and outlets fed by each feeder and circuit. Plans and diagrams on cloth should be furnished to the hospital to indicate the location and size of all feeders and circuits. The diagrams should show the wiring of all call and low potential systems, in addition to the feeders. Wiring diagrams of special equipment and controls should be furnished. Such plans and diagrams are of special value at a later time if repairs, alterations or extensions should be needed. Catalogs and operating instructions for all equipment and controls should be assembled and bound as a guide for operation and repair.



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Who Are Our Hospital Leaders?

(*Continued From Page* 88.)

can we ever attain that goal where we sublimate our own individual beliefs to the common good? In addition to our various religious and racial hospitals, we have also our university hospitals as opposed to those without university affiliations. Certainly we should do everything in our power to bring about a co-ordination of our services. It's something for the future anyhow. Right now, frankly, I am trying to put our own house in order. There is the physical plant that always needs so much more than we have to put into it. And finances—what are we going to do about hospital finances?"

But even the stark realism of present day hospital finances failed to rout wholly the idealist. "Speaking about our being of so many different faiths, so many different races, perhaps our thinking has been wrong from the very start. Why a Jewish hospital, why a Presbyterian hospital, why a Catholic hospital? Aren't we all serving the sick of our communities regardless of race, creed or color? Why thus restrict ourselves? Isn't such segregation precisely what we are trying to overcome? Should our efforts not be directed toward hospitals that are run by all of us, representing a cross section of every community, in such manner as to assure every man, woman and child in the community the highest type of professional care?"

The voice of the idealist died away on this note. The realist looked at his watch. "It's 3:30. Do you realize how long we have been here talking hospitals? Forgive me if I rush off. Believe it or not, I have a hospital meeting at 4 o'clock. Next time you meet me in St. Louis, I hope I'll have more to report."

And unless we are very much mistaken, Mr. Einstein one day will have much more to report. We shall be hearing from him again not in terms of one hospital alone but in terms of hospitals generally. His is that kind of leadership.

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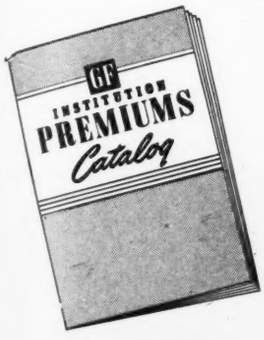

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NEWS DIGEST

New York Hospital Studies Division of Nursing-Housekeeping Duties

NEW YORK.—Such work as cleaning utility rooms, cleaning beds, chairs and bedside tables after patients have been discharged and caring for cleanliness of linen and other rooms can be placed under the housekeeping department instead of the nursing department, according to the first results of an experiment to aid in relieving nurses of nonprofessional duties. The results were announced last month by Virginia M. Dunbar, director of nursing service at the New York Hospital.

Designed to examine the division of duties between the nursing service and the housekeeping department of the hospital in order to release nurses for direct care of the patient, the experiment was begun with the addition to the nursing staff of a full time nurse as administrative assistant in charge of supplementary workers, Miss Dunbar explained. These supplementary workers include attendants, ward clerks and orderlies.

Transfer of certain functions to the housekeeping department, Miss Dunbar said, will permit nursing attendants to curtail their housekeeping duties in order to make empty beds, fill water carafes, arrange flowers, run errands for patients and perform other minor nursing duties which in the past have often fallen to the student or graduate nurse. "Although in many cases these duties are inextricably a part of the work of the nurse," said Miss Dunbar, "best service to patients requires that, whenever possible, the ward be staffed with supplementary personnel to provide for frequent repetition of such tasks during each day."

Another step toward the best possible patient care, said Miss Dunbar, is the decision to appoint a registered male nurse to supervise the orderlies in the hospital. The orderly group, she explained, performs many of the nursing duties for male patients and, as members of the supplementary staff, will now be under the supervision of a well qualified man who can aid in their orientation. This, in turn, will relieve the nursing staff of interviewing, teaching and supervising new orderlies in procedures and hospital policies.

An in-service training program for the supplementary nursing staff, under the direction of the administrative assistant in charge of supplementary workers, has also been inaugurated, said Miss Dunbar. These classes are designed to teach the workers the dignity of their positions, attitude toward patients, hospital procedures, basic hospital housecleaning, personnel policies of the hospital, safety, health and other information pertaining to the best and most efficient care of the sick.

"This step, too," said Miss Dunbar, "will be a timesaver for the nurses, who have had to take many hours from their professional duties to instruct new attendants or ward clerks in their functions."

First Application Approved

WASHINGTON, D. C.—The first construction project application to be completely approved under the Federal Hospital Survey and Construction Act was given final approval October 22 when Surgeon General Parran okayed plans for an 82 bed general hospital, public health center and outpatient clinic at Langdale, Ala. The project, which was approved under the name of the Chattahoochee Valley Hospital Society, will cost $1,663,287, including site, equipment and architect's fees.

Form New Association

BILLINGS, MONT.—The Montana Hospital Association voted October 22 to become a charter member of the newly organized Upper Midwest Hospital Association. Sister Mary Lawrence of the Kalispell General Hospital, Kalispell, Mont., and Harry C. Wheeler, Billings Deaconess Hospital, were elected members of the Upper Midwest board of trustees representing the Montana association. The Montana association will also continue as a member of the Association of Western Hospitals, Mr. Wheeler, president of the Montana group asserted.

Call Nursing Conferences

WASHINGTON, D. C.—Called by national nursing groups, 300 nurses from 22 states attended an emergency conference here October 23 to attack "basic nursing problems." Similar conferences are scheduled to be held soon in New York and Chicago.

Doctors Report on Effects of Bed Rest and Immobilization

NEW YORK.—Bed rest and immobilization lasting more than ten days may have serious effect on metabolic and physiological function, Doctors John E. Deitrick, Donald Whedon and Ephraim Shorr reported at a recent meeting of the New York Academy of Medicine. Doctors Deitrick, Whedon and Shorr were reporting the results of tests carried out at the New York Hospital and the Russell Sage Institute of Pathology.

In the tests four men were put to bed for a period of from six to seven weeks and immobilized in plaster casts following observations made over a control period during which the subjects were ambulatory. Further observations were made during a four week recovery period following their removal from the casts. According to the authors, immobilization "caused a definite decrease in the size and strength of the legs. There was definite loss of nitrogen from the body. Calcium loss increased slowly and became marked at the fifth week with a definite hazard of renal stone formation.

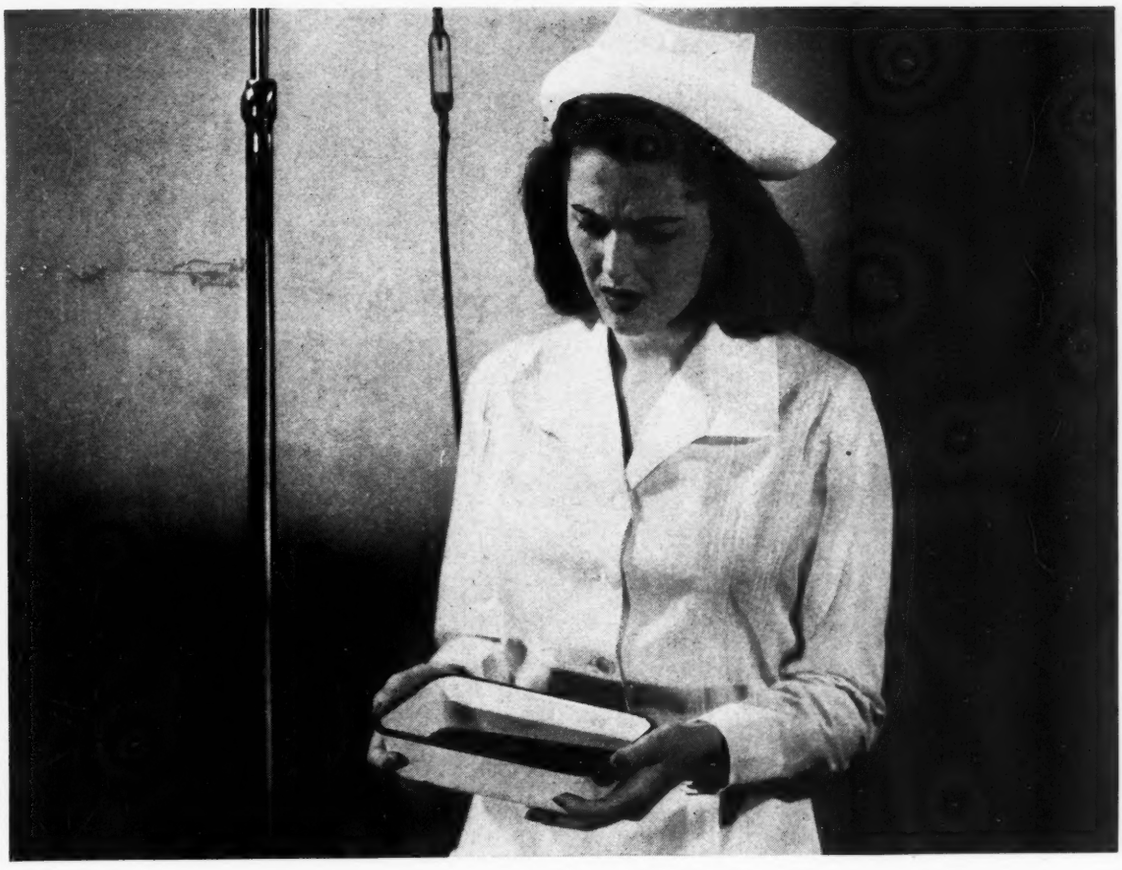
Stiffness in Knees, Ankles

"Control of the blood vessels of the legs was impaired and this became marked after two weeks in bed. The men complained of stiffness of the knee and ankle joints after the fixed bed experiment and this persisted in two of the men for several weeks after being discharged from the hospital.

"It is well known that patients may feel weak and dizzy on first getting out of bed after an illness. After one week of immobilization in bed there developed (in our subjects) an increasing tendency to faint when placed in an upright position. This loss of circulatory control in the upright position became more marked as bed rest continued."

Loss of circulatory control may be almost completely prevented, Dr. Deitrick reported for the group, by use of electrically driven oscillating beds which tilt back and forth on the long axis and can be adjusted to tilt either the feet or the head down. Use of the oscillating bed will reduce calcium loss and thus may be important in preventing kidney stone formation, the investigators added.

"During the first ten days of immobilization and bed rest there is little evidence of physiological and metabolic damage to the human body," the report said. "After such a period of time, rather serious effects became manifest."



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Iowa Hospital Advisory Committee Withholds Approval of State Plan

DES MOINES, IOWA.—Approval of the state hospital plan for Iowa was withheld by the hospital advisory committee at a meeting last month when Gerhard Hartman, superintendent of the State University Hospital at Iowa City, objected that the proposed plan contained "serious gaps and omissions and serious commitments."

Following lengthy discussion based on the points raised by Mr. Hartman, the committee decided to wait for a month or more before approving the plan. Meanwhile, the state health department, which presented the plan, will add statistical data supporting its recommendations.

Among other objections, Mr. Hartman expressed the opinion that the plan, whether right or wrong, contained many conclusions not supported by explanatory data. Opposing the view of Dr. Walter Bierring, state health commissioner, that the needed material was already in the plan, Mr. Hartman favored more intensive investigations of local hospital needs.

Further Study Needed

Chiefly, criticism of the plan centered on the possibility that further study might show facilities planned in excess of actual needs in certain areas. Sister Mary Edmunds of St. Joseph Mercy Hospital, Dubuque, supported the Hartman view that the proposed facilities would impose a burden of continued operating expense on local communities. "It's one thing to build hospitals, but another to maintain them," she commented during the discussion.

Verne Pangborn, director of the state hospital program, and other health department representatives present at the advisory committee meeting denied there was danger that Iowa would become overbuilt from a hospital standpoint, or that community ability to finance continued hospital operation had been overlooked in the plans.

A word of caution to planners was added by Dr. Charles A. Nicoll of Panora, a practicing physician. "Right now people have money and they'll call you to come whenever the baby is sick," he warned. "A few years back, they would wait until the third day and then come in and ask for some medicine for the baby.

"Let corn go back to 50 cents a bushel and hogs to $5 a hundred, and people won't want such good medical care."

Explaining his position to THE MODERN HOSPITAL, Mr. Hartman said the health department gave advisory committee members only two days to study the plan before meeting to discuss it. "This is hardly a sufficient amount of time to study it thoroughly unless you are well acquainted with hospital trends, plans, organization and activities," he pointed out.

Mr. Hartman also criticized the health department for releasing the plan, including the list of proposed projects and their priority ratings, to the press the day before the advisory committee met.

In addition to Mr. Hartman, Sister Edmunds and Dr. Nicoll, members of the advisory committee are: T. W. Purcell, Hampton; K. T. Prentis, Mount Ayr; Harold K. Wright, Sioux City; Dr. David H. Gran, Muscatine; Dr. Con R. Harken, Osceola; Anna C. Carlson, Ida Grove; Mary Woodward, Whittemore, and Cora Abraham, Mount Pleasant.

Army Appointments for Nurses

WASHINGTON, D. C.—One hundred and fifty-three nurses received recess appointments in the regular army early in October, according to an announcement of the surgeon general's office October 3. Also appointed to the regular army were 31 hospital dietitians and 19 physical therapists. All had served as temporary officers and reserve officers during World War II. In addition, appointments were tendered three occupational therapists who had been serving as civilian employes in the army medical department.

The deadline date for applications in the army nurse corps and the women's medical specialist corps has been extended from September 30 to November 30.

Approval of Three New Blue Cross Plans Brings Total to 91

CHICAGO.—Three new Blue Cross plans were approved by the American Hospital Association's board of trustees at its meeting in St. Louis last month, Richard M. Jones, director of the Blue Cross commission, announced. This brings the total of approved Blue Cross plans to 91, Mr. Jones said. The newly approved plans are: West Georgia Hospital Service Association, headquartered at Columbus, Ga., Sam M. Butler, executive director; Mississippi Hospital and Medical Service, headquartered at Jackson, Miss., Richard C. Williams, executive director; Parkersburg Hospital Service, Inc., headquartered at Parkersburg, W. Va., Ray A. Wyland, executive director.

The area covered by the West Georgia plan is, as prescribed by Georgia law, a circle of 50 miles' radius centered on the headquarters city, Columbus. The Mississippi plan covers the entire state. The Parkersburg plan covers principally the counties of Wood, Pleasant, Ritchie, Wirt and Calhoun in West Virginia. Medical and surgical coverage, in addition to hospitalization benefits, is offered through companion plans coordinated with the Mississippi and Parkersburg Blue Cross.

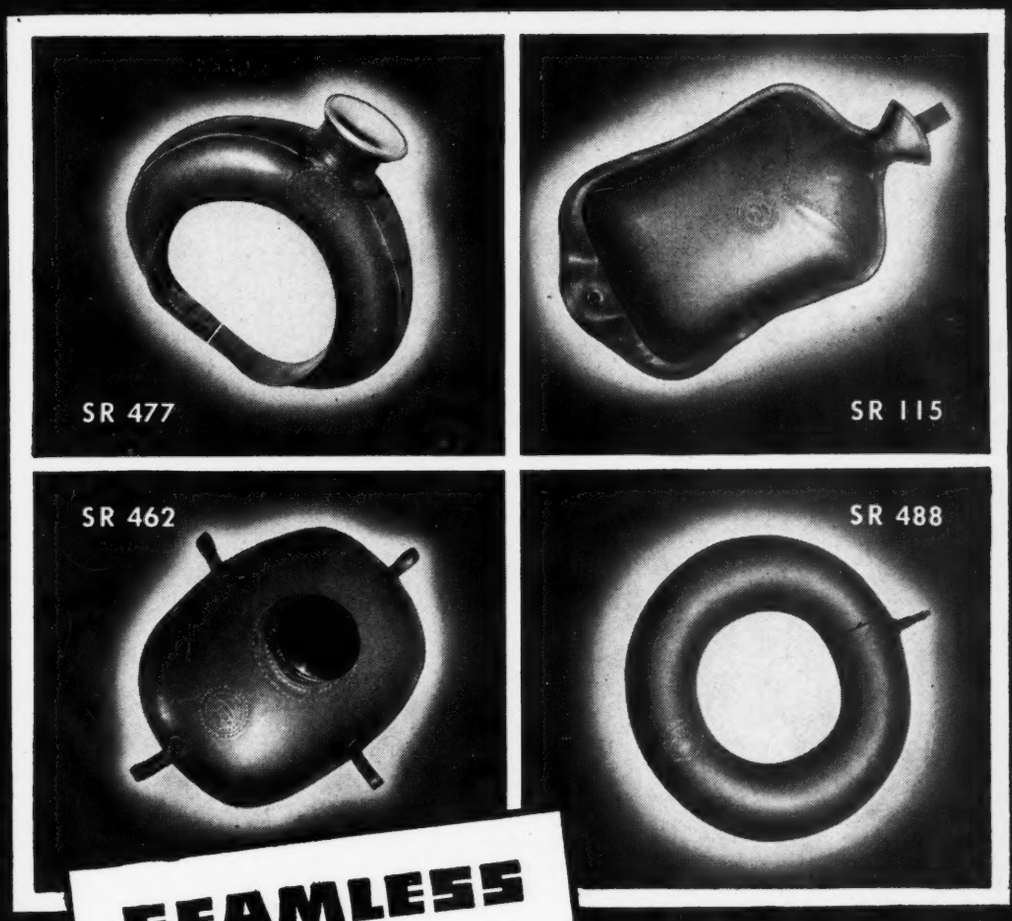
In announcing approval of the new plans, Mr. Jones stated that total Blue Cross enrollment in the United States and Canada has now reached 29,000,000 persons. With the exception of Arkansas, Blue Cross hospitalization prepayment is now offered in every state in the Union, as well as in seven Canadian provinces. During the year ended last July 1, Blue Cross plans paid $177,420,996 to hospitals for care of members. This represented 85 per cent of subscription income, it was reported.

Medical Schools Must Expand Facilities, Parran Tells A.P.H.A.

ATLANTIC CITY, N. J.—Medical schools must expand their facilities now to provide enough physicians for adequate medical care in future generations, Dr. Thomas Parran, surgeon general of the U. S. Public Health Service, said in an address at the annual meeting of the American Public Health Association. Dr. Parran asserted that 40,000,000 people in this country lack modern health services. He recommended that medical schools begin now to increase the annual number of students graduated by 50 per cent.

Dividing lines between therapeutic and preventive medicine are fading out, Raymond B. Fosdick, president of the Rockefeller Foundation, told the assembled public health workers, and some means must be found whereby the burden of illness can be spread more equitably. The trend in this direction, he said, cannot be stopped by "attacks of frightened orthodoxy or false and silly charges of adherence to an alien philosophy." Mr. Fosdick said medicine and public health must unite to meet human needs. "Disease has no political ideology," he declared.

In a special message addressed to the association, President Truman said, "There is no more important function of democratic government than to improve the health and increase the well-being of its people. Not only private funds but additional public funds and facilities must be provided to do this." The President urged the adoption as promptly as possible of a national health insurance system.



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Massachusetts Group Advises Separate Accounting for Medical, Hospital Service

BOSTON.—Complete separation of hospital and "hospital-medical" services for purposes of accounting and billing will eliminate confusion regarding responsibility for payment of these services by Blue Cross and other insurance plans, according to a report recently made by a special committee studying these problems in Massachusetts hospitals. The committee included representatives of the Massachusetts medical society and hospital association, the medical service plan, Blue Cross and the specialties of radiology, pathology and anesthesiology.

Basing its recommendation on replies to a survey questionnaire directed to participating physicians in Massachusetts Medical Service, the committee recommended:

1. That medical costs of hospital care be separated from nonmedical costs in hospital accounting and appear separately on statements submitted to the hospital patient.

2. That bills for all medical services be rendered in the name of the physician performing the service.

3. That hospital charges be based on the principle that each department be self supporting, so that "neither the hospital nor the physician rendering the service will exploit the patient or each other."

4. That fees for medical service collected by the hospital be established by a committee representing the staff, the governing board and the administration of the hospital.

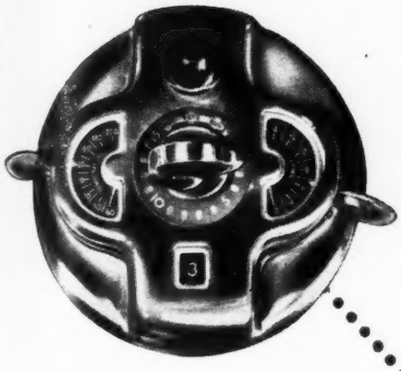
5. That the financial arrangement between hospital and physician be established on a salary, commission fee or other basis in the best interest of the patient, the community, the hospital and the physician.

Medical-hospital services were defined by the committee as "those services other than administrative, rendered by a registered physician directly or indirectly to or in behalf of an individual patient for the obtainment and interpretation of data, including consultation and advice, for the diagnosis, treatment and prevention of disease. Such services will embrace the general and special practice of medicine, surgery and obstetrics, and the practice of the related specialties, including anesthesiology, physical medicine, radiology, pathology and clinical pathology, including bacteriology, clinical chemistry and other clinical laboratory specialties."

Nonmedical hospital services were defined as "those services, technical and nontechnical, provided by other than a registered physician, which are required for the care of patients, the making of a diagnosis and the treatment and prevention of disease; and those services rendered by a registered physician in an administrative capacity or as the head of a department when such services do not include the obtaining or interpretation of information in behalf of an individual patient."

On TB Sanitarium Board

CHICAGO.—Ernest E. Irons, M.D., secretary of the board of trustees, the American Medical Association, and Francis R. Lyons, a restaurant operator, have been appointed to the board of directors of the Municipal Tuberculosis Sanitarium. The third member of the board, whose appointment was announced some weeks ago, is Dr. Herman N. Bundesen, president of the Chicago Board of Health. Dr. Irons and Mr. Lyons replace Dr. David J. Davis, board president, and Harry J. Reynolds who have resigned. The new appointments were made by Mayor Martin Kennelly following studies of sanitarium operation made by medical society and other investigating committees.



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2000 Dietitians Convene in Philadelphia; Lulu Graves Receives Copher Award

By MARY P. HUDDLESON

Undaunted by mid-summer heat the nearly 2000 members of the American Dietetic Association and the hundreds of their friends who attended the 30th annual meeting in Philadelphia, October 13-17, fairly overran the City of Brotherly Love. Everywhere one went, everywhere one looked, there were dietitians attending meetings and viewing exhibits, points of professional interest and the many historic spots on the narrow streets of the old city. With their characteristic energy they took notes, discussed mutual problems and sampled the culinary offerings of the locale.

In her presidential address before the house of delegates, Mable MacLachlan warned that professional prestige and good public relations depend on the efforts of the individual member. The secretary announced a total of 1004 new members, 84 per cent of whom have completed approved training courses. The educational director announced that 71 dietetic internships in various institutions have been approved by the association's executive board and 676 dietetic interns are enrolled for 1947-48, representing a decrease in enrollment of 10 per cent over the preceding year. The director of the placement bureau announced a 25 per cent increase in registrations and a 65 per cent increase in placements over last year. A total of 1074 new positions was listed, 71 per cent of which were in hospitals; 12 per cent, in college food services, and the remainder in the fields of commercial work, public health and industrial and school lunchroom feeding.

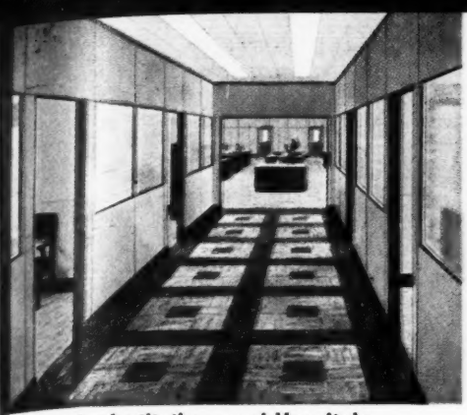
In other reports before the house of delegates it was suggested that the house be "a sounding board to determine the opinions of the membership," that it serve to give "better representation to the membership" and that the 161 members be a deliberative or policy making body. .

The following were elected members of the council of the house of delegates with the chairman serving as a member of the association's executive board: Mary McKelvie, chairman; Evelyn Carpenter, Mrs. Beula Becker Marble, Mrs. Cora Kusner, Capt. Edna Cox, Mary Northrop and Ruth Gordon.

The opening session stressed the world problem of feeding peoples. Katherine Fisher, who is one of the two women serving on the Consumer Service Section of the Citizens Food Committee under Charles Luckman, stated that "no national organization is of more importance that the American Dietetic Association in influencing the eating habits of America." Other speakers included: W. R. Aykroyd, director, Nutrition Division, Food and Agriculture Organization of the United Nations; F. G. Boudreau of the Milbank Memorial Fund, and R. R. Williams of the Research Corporation, New York.

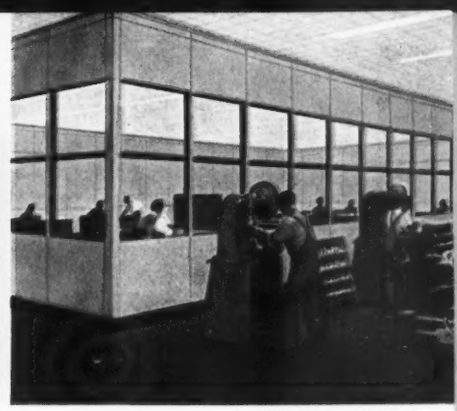
Dr. Williams believed that the only sure way of saving grain in the present emergency is "to stop feeding it to hogs and cattle. . . . Systematic depletion of our herds and flocks by killing off poor specimens and feeding the remaining animals on grass would save a tremendous amount of grain." Other points of view were expressed later in the week, based on the first hand observations of dietitians who had served in foreign countries.

Prior to the opening of the annual meeting the executive board of the association meeting in special session took action on the government's campaign to save food. A resolution of cooperation was dispatched to President Truman in which it was emphasized that the serious need to save food should be met without detriment to the national standard of nutrition and that substitute foods



. . . for Institutions and Hospitals

. . . for Schools



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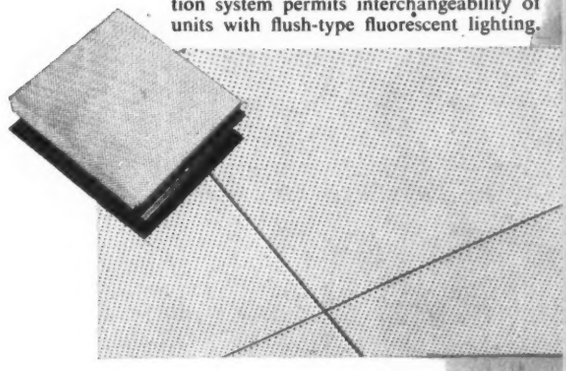

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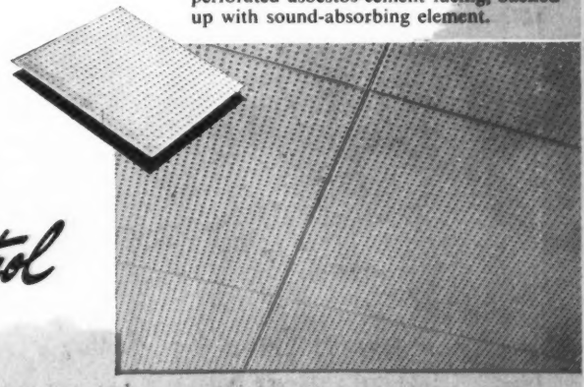

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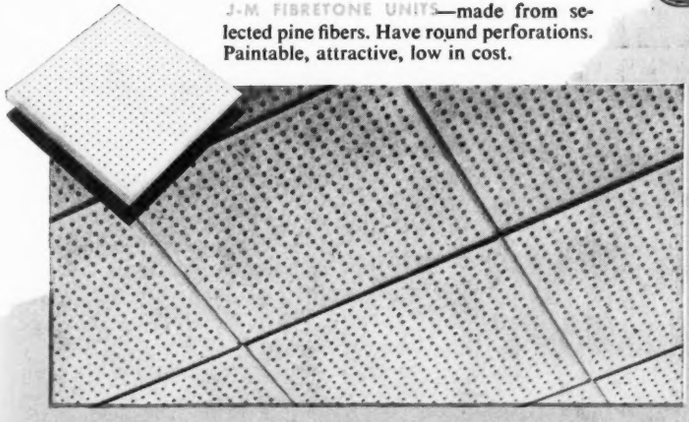
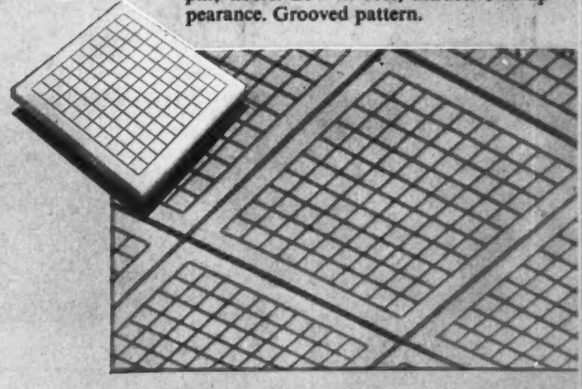


J-M [illegible] UNITS—made from selected pine fibers. Low in cost, attractive in appearance. Grooved pattern.



"should provide the right kind of nutrition." The resolution further pledged the cooperation of the association's membership in maintaining adequate standards of nutrition. Various members took part in a forum on the food emergency over station WPEN.

That dietitians are alert to the needs of the present and open-minded to the lessons of the past was reflected in their attendance at sessions devoted to personnel management and the historical aspects of the profession. Perhaps these two interests and that of public relations could be said to have topped all others as major concerns at this meeting.

In the words of M. J. Wise Jr., speaking at a session on management and training of employes, "we have made great progress in everything but handling human material and national resources." Management, he believed, should determine policies, only after consulting with supervisors—those "with authority to hire, fire, discipline or otherwise affect the status of an employe."

Policies, which are "general statements of desires," should then be issued as a line order and should allow some latitude in their application. The supervisor, *i.e.* the dietitian, is a better judge of the fitness of an employe. She should be permitted to discharge an employe from her department "but not necessarily from the institution."

Dietitians, like most professional people chary of the limelight, were warned by a speaker at a luncheon devoted to public relations that they should get away from the idea that any woman who has something to say in public should say it "in a crew haircut and a pair of old golf shoes."

Specific problems of employe management were discussed in programs concerning training. Mary Ruth Curfman believed that the solution of the training problem "requires patience, courage, tenacity and above all a personality that wins the cooperation not only of food supervisors and employes but of the entire plant personnel as well." Magdalin Klobe Espy stated that in establishing a training program we must first make every employe realize that the hospital exists primarily for the care of the patient. Then "we need to develop pride in their work and understanding of good service."

Better sanitation and accident prevention were other features of practical interest. Dr. Israel Weinstein, commissioner of health of the City of New York, stated that of the 50 or more diseases that can be readily transmitted from person to person at least half of them can be carried by food.

Accidents, Kent W. Francis of the National Safety Council stated, are *prima-facie* evidence that conditions, employe practices or both are not completely under control. We must get away from our traditional thinking that "accidents will happen."

Objectives Described

The needs of the hospital and institution without the services of a dietitian were discussed by Kathleen Van Cleft, consulting dietitian for the Vermont Department of Health, and Jane Hartman, serving likewise for the Maryland State Department of Health. The requirements for such work, the objectives and the problems were described.

At the closing session, the annual banquet, Dr. Helen Hunscher was inducted into office as president; Helen E. Walsh, nutrition consultant, California State Department of Health, was named president-elect, and Fern Gleiser, professor of Institutional Management, University of Chicago, was elected treasurer.

The highlight of this meeting was the awarding of the third annual Marjorie Hulsizer Copher Award for achievement in the dietetic field to Lulu G. Graves, first president of the American Dietetic Association, now honorary president, and for twenty-seven years editor of the dietary department of The Modern Hospital. The 1948 meeting of the association is to be held in Boston.

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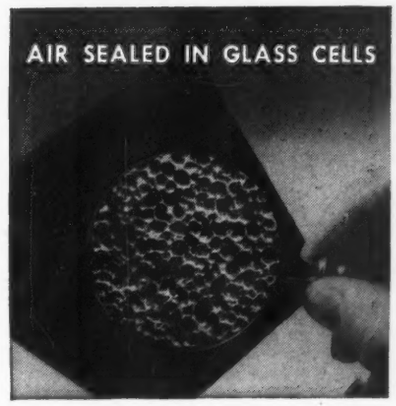

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"Will Stay With V.A. as Long as My Staying Is Essential"—Hawley

By EVA ADAMS CROSS

WASHINTON, D. C.—Dr. Paul R. Hawley, V.A.'s medical chief, refused to commit himself one way or another at a meeting October 8 with representatives of the press anxious to learn if his departure from the Veterans Administration is imminent. He will not leave, he declared, as long as General Bradley wants him to stay.

"So long as my staying here is essential to the development of V.A.'s medical program, I am not going to quit," said Dr. Hawley, "but I must be convinced that my staying is essential. One never knows in a political world what will happen, but if the program can be held together another year, its ultimate success will be assured," he continued. The goal of the program, he pointed out, is to bring to the veteran patient the best in American medicine, the best trained medical men in the country.

When asked outright if he would accept General Bradley's job as Veterans' Administrator, Dr. Hawley replied that, obviously, he could not answer such a question.

Dr. Hawley feels that V.A.'s medical program is making a definite impact on the progress of medicine in this country. In a talk given a day or two earlier, he said that the best medicine in the country is practiced in teaching hospitals. That was why, in order to give the veteran the best in American medicine, as many veterans' hospitals as possible must be teaching hospitals.

One half of veterans' hospitals, 62 of 124, are now affiliated with schools of medicine, Dr. Hawley explained. Fifty-six schools of medicine are cooperating in the program and arrangements with others are being made. There are 1867 residents in training in V.A. hospitals—every one of these residencies having been approved by the governing specialty board. In addition to the residents, there are 139 career doctors in training positions which will qualify them for their board examinations.

Thus, the Veterans Administration is giving more than 2000 physicians post-graduate training of a quality that meets the approval of the most exacting professional standards boards in the world, V.A.'s medical director said. This is a byproduct of improvement in patient care, he added. It is not the end in view, but the most important of all means to that end.

More Public Health Nurses Are Needed

WASHINGTON, D. C.—The 1947 annual census of public health nurses indicates the present total, 21,171, is inadequate to supply public demand for public health nursing services, the Federal Security Agency announced October 5. The shortage is indicated by the 2489 vacancies in budgeted positions reported by the states; by the 1087 counties without rural public health nursing services; by the pressing need for nurses in new and expanding programs in the fields of mental hygiene, cancer control, nutrition and others.

In 29 states, the census shows, the average population per nurse was greater in 1947 than in 1946. In 21 states the ratio averaged one public health nurse for each 10,000 of the population; in one state, a single nurse to each 20,946 persons. Only 17 states had as many as 10,000 persons to one public health nurse in 1946.

The American Public Health Association sets a standard of one nurse for each 5000 of the population. This ratio does not include bedside nursing service. In 1946 and 1947, nine states, Alaska and the Virgin Islands met this standard. In 1947 no state came up to the standard established by the National Organization for Public Health Nursing—one nurse to each 2000 persons, for service including bedside nursing.

Taft Outlines His Program of Public Welfare

By EVA ADAMS CROSS

WASHINGTON, D. C.—Senator Taft in a recent address said the United States has the best medical service in the world and "it seems idiotic to throw it away and start a brand new experiment." He was outlining his public welfare program which will undoubtedly be considered at the next session of Congress, according to the Senator. The "new experiment" to which he referred is national health insurance, urged by President Truman.

His plan is based on the state-aid principle. Briefly, it proposes that every state be invited to prepare a plan by which free medical and hospital service can be given to all those unable to pay for it. Private charitable and local health services are to be coordinated into the plan so there will be no duplication. The state plan would, however, have to provide that such service be made comprehensive and that all the gaps be filled in.

The Senator called attention to the fact that we have already adopted part of the plan in the Hospital Survey and Construction Act. That bill, he emphasized, has already brought about many comprehensive state plans to improve hospital service and make it universal.

For the new health plan, as sponsored by Mr. Taft, the federal government would put up a substantial part of the money required for extension at an estimated cost in the beginning of 200 million dollars a year. The bill encourages the formation of voluntary health insurance funds. It authorizes the states to use the federal money, if they desire to do so, in making payments to voluntary funds in effect to pay health insurance for those unable to pay it. This could be done when the state does not desire to furnish medical care directly.

"The brilliant progress in medicine in this country has been due largely to the freedom of the medical profession. Let us work on this foundation which we have," concluded Mr. Taft.

Stresses Department Autonomy

WASHINGTON, D. C.—Secretary of Defense Forrestal said here at his first press conference September 23 that the departments of the Army, Navy and Air Force will remain as autonomous as possible under the gradual program of unification. Mr. Forrestal was asked about the establishment of joint army and navy hospitals as a method of savings to the taxpayer. His answer was that he expected to get the facts and merge activities wherever practical, "as long as it does not dilute the quality of the service."

Scientific Research Board Issues Vols. 3 and 4 of Report

WASHINGTON, D. C.—"Administration for Research," a second report of the President's Scientific Research Board, was submitted to the President October 3 by John R. Steelman, chairman of the board.

This volume, Number 3, of Science and Public Policy, proposes four specific steps:

1. Establishment of an Interdepartmental Committee on Scientific Research and Development.

2. Creation of a unit in the Bureau of the Budget to review federal scientific and research development programs in relation to total government activity.

3. Designation of a member of the White House staff by the President for scientific liaison inside and outside the government.

4. Establishment of a National Science Foundation along sound administrative lines.

The report also recommends that top-flight scientific positions in the federal government carry a yearly salary of $15,000.

In its fourth volume, "Manpower for Research," issued October 8, the board reported that the United States faces a serious under-supply of highly trained scientists and technicians. Increasing this supply is a task which cannot be performed overnight, the report asserts, and colleges and universities will have to do the fundamental part of the job. Schools must be enabled through improving their financial situation to do the job.

On this same high note of urgency the report sets forth a remedial program calling for adequate financial support to colleges and universities and to deserving students. There are some 600,000 students now enrolled in science and engineering courses. But the extreme shortage of scientists compels the grave doubt that the 600,000 students can be adequately trained unless broad action is taken promptly to assure that the students have the facilities and scientist-teachers they need.

Three specific programs are offered to meet the problems causing the shortage of trained scientists:

1. Development of sources of financial support for educational institutions to permit expansion of faculties and increases in instructional staff and salaries—all as a part of a general program for improving higher education.

2. Development of a broad program in support of basic research in the universities to ensure a foundation for applied and developmental science and a training ground for experts. To carry out such a program, a National Science Foundation should be employed to strengthen the weaker but promising institutions.

3. Establishment of a national system of scholarships and fellowships in all fields of knowledge, as the benefits under the Servicemen's Readjustment Act expire.

The report recommends that a scholarship program be initiated immediately based upon evidence such as was presented in the Bush report. It calls for further study of such a program to provide additional financial aid wherever needed to maintain able students in colleges and the graduate schools.

Funds should be made immediately available, advises the report, for large-scale expansion of the post-doctoral fellowships similar to those now provided by the National Research Council, by the Guggenheim Foundation and on a smaller scale by other private foundations. Academic positions should be supported by grants-in-aid to match positions in applied research in government and industrial laboratories. Educational institutions should also be supported by grants-in-aid to provide adequate equipment, library and other facilities and relief of staff from excessive teaching duties.

V.A. Sets Up Center for Intensive Study of Heart Disease

WASHINGTON, D. C.—A new research center is being established at Mount Alto Hospital here for intensive research into heart disease, the Veterans Administration announced October 12. The center will conduct scientific investigations of cardiovascular physiology and pathology. V.A. doctors will be specially trained here through postgraduate study and resident training. In addition, the center will provide a consultation service to the V.A. medical supply section through evaluation of new instruments and equipment.

To provide the most efficient service, the center will have eight major functions: treatment, clinical research, cardiovascular roentgenography, cardiac catheterization and hemodynamics, electrocardiography, pathology, statistical research and postgraduate teaching. Ultimately, departments for research in biochemistry and biophysics will be added.

The new research center, a part of which is already in operation, was developed under the supervision of Dr. George P. Robb, widely known cardiologist and assistant medical director of the Metropolitan Life Insurance Company.

A.Ph.A. Administering Research Award

WASHINGTON, D. C.—The American Pharmaceutical Association is now receiving nominations for the Iodine Educational Bureau Award, according to an announcement of A.Ph.A. September 30. The award, recognizing outstanding research in the chemistry and pharmacy of iodine and its compounds as applied in pharmacy or medicine, consists of $1000 and a diploma setting forth the reasons for the selection of the recipient.

Any member of the A.Ph.A. may propose a nominee by submitting specification of the work to be considered in the competition, a biographical sketch of the nominee, including date of birth, and a list of his publications. To be eligible for the 1948 award, nominations must be received before January 1.

Polio Study at Negro Schools

NEW YORK.—Grants to Negro schools and hospitals to train students in the treatment of poliomyelitis were announced by the National Foundation for Infantile Paralysis. Foundation officials said the grants are aimed at increasing the opportunities of Negroes to obtain such training. The largest single grant, $60,000, was made to Tuskegee Institute where the foundation maintains an infantile paralysis center.

Four Groups Stress Need for Facilities for Chronically Ill

CHICAGO.—The need for additional facilities for rehabilitation and other features of treatment of chronic diseases is far from being met today, and there is an estimated backlog of 2,000,000 persons needing these services, according to a joint statement released recently by the American Hospital Association, the American Medical Association, the American Public Health Association and the American Public Welfare Association.

The statement urges that facilities for care of the chronically ill be integrated with other medical care facilities in a coordinated program which will give the entire population ready access to the needed services.

Among other things, the four organizations urged expansion of public health service and wider use of practical nurses and nurse aid personnel to enable more chronically ill persons to be cared for at home.

"The general hospital as at present constituted is often unsuited to the care of long term patients," the report states. "It may lack adequate departments for physical therapy, occupational therapy and rehabilitation, as well as sun porches, recreational facilities, educational facilities for children and an understanding of the social and psychologic needs of the chronically ill." But "hospital facilities for long term illness should be built in the very closest relation to teaching centers and general hospitals," and "most patients with chronic illness that requires hospitalization are best cared for in a unit of the general hospital especially designed to meet their needs."

Private and public nursing homes "should be brought under state licensure laws in which provision is made for minimum standards and regular inspection," the joint statement continues. Suitable county homes should be converted into nursing homes and brought under the same laws. Many new institutions are also needed. But "undoubtedly the most neglected aspect of chronic illness is that of convalescence and rehabilitation," according to the report.

"Planned convalescence and rehabilitation are particularly important in chronic disease. The chronically ill have to be made conscious of their limitations early in the course of the disease, and many of them must be retrained for new occupations so that they may stay within the limits of activity prescribed by their illness and yet maintain their economic independence."

Charges Hospital With Neglect

NEW YORK.—An American Legion post in Westchester County has charged that Grasslands Hospital at Eastview, a county institution, was guilty of "careless, irresponsible, cruel and reprehensible" treatment of a veteran patient, the *New York Times* reported last month.

County officials said an investigation was being made of the Legion post's charges. The hospital's policy is to admit any person needing care regardless of economic status, it was pointed out.

The Legion post charged that a 59 year old veteran patient referred to the hospital by his physician was released prematurely in a dangerously ill condition. The patient later died.

Hospital Starts Construction

LANCASTER, N. H.—Construction of a new 35 bed hospital has been undertaken here to replace the present 22 bed wood building in use for the last twenty-five years. The new three story building is expected to be completed about the end of this year. The hospital will be called the Beatrice D. Weeks Memorial Hospital. Mrs. Christine G. Morrison is the superintendent of the hospital.

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Basic Medical Research Gains Impetus Through Public Health Awards

By EVA ADAMS CROSS

WASHINGTON, D. C.—Somewhat more than $10,000,000 in Public Health Service awards has gone for basic medical research in the last year and a half or so, Federal Security Agency announced October 1. These awards, made between Jan. 1, 1946, and Sept. 15, 1947, supported research projects in 34 hospitals and clinics and in 97 universities and colleges. An additional 62 research grants were made to foundations, sanatoriums, health departments and individuals. Some 629 scientists shared in these grants.

Dr. C. J. Van Slyke, chief of the Division of Research Grants and Fellowships of the National Institute of Health, listed these awards in a recent report to the Federal Security Administrator. Dr. Van Slyke pointed out that the program launched in 1945 is planned and directed by 250 of the nation's top civilian scientists for the purpose of producing the research which they consider most essential to the improvement of the country's health.

Research grant funds may not be used to relieve an institution from its ordinary teaching, administrative or research responsibilities, according to Dr. Van Slyke's report. Wide latitude, however, is allowed the responsible scientific investigator in the use of such funds. Recipients of awards are given complete freedom to conduct projects in whatever ways they choose and are not subject to any governmental review.

The report called attention to the fact that the largest sum, $1,669,793, was awarded for venereal disease research. The second highest sum, $1,241,510, went for research on cancer, and the third highest, $703,187, was spent in research on heart disease and other cardiovascular illness. Nutrition and biochemistry projects accounted for $682,358; prevention and cure of common colds, for $133,453, and dental projects, for $135,607.

Naval Dental School Graduates 16 Officers

WASHINGTON, D. C.—The naval dental school at the National Naval Medical Center, Bethesda, Md., held graduation exercises October 3 for 16 dental corps officers. The officers had successfully completed a six months' postgraduate course.

The Navy Department has announced that the next examination for applicants to the navy dental corps will be held November 3 at 10 naval activities throughout the country. Applicants must hold a degree in dentistry from an accredited dental school, must be citizens of the United States and must be between the ages of 21 and 32 at the time of acceptance of appointment.

Recent legislation provides that officers appointed in the naval dental corps within the next five year period shall be entitled to receive compensation at the rate of $100 per month, for each month of service, in addition to the pay and allowances otherwise provided for.

Vaccinate Against Flu

WASHINGTON, D. C.—Army personnel is being vaccinated against influenza, the Office of the Surgeon General revealed recently. Vaccination of all military personnel began in October. Those entering the service prior to April 1 next year will receive influenza vaccine along with their initial immunizations.

Laboratory tests will be made in the field on early representative cases of influenza to establish outbreaks. In addition to the A and B viruses, the vaccine contains an A-variant cultured from the distinctive type of influenza that occurred at Fort Monmouth, N. J., last year. The army is on the lookout for any new strains that may occur.

H.S.A. Increases Rates to Hospitals for Care of Charity Patients

WASHINGTON, D. C.—Health Security Administration will pay Washington hospitals $7.50 a day for charity patients next year, according to an agreement reached October 1 by H.S.A., the Hospital Council and the Community Chest. This figure represents a 50 per cent increase from the present rate of $5 per day. The increase will depend, however, according to Chest officials, on an unusually generous response to this year's fund raising campaign.

In the meantime, the budget bureau of the District of Columbia has set a daily rate of $13.90 for every indigent patient it sends to Freedmen's Hospital for general care. The rate for tuberculous patients supported by District tax funds was hiked nearly 100 per cent from the present $5.20 per day to $10.20. The new fees are retroactive to July 1.

Budget bureau officials declare that the whole rate structure will be reviewed at the end of six months. Freedmen's rates include an allowance of about $1.40 per day for outpatient care which is not included in figures given for other hospitals. Moreover, these indigent rates include all hospital costs—drug and operating room fees.

Gallinger Municipal Hospital figures its operating cost at $9.09 per day. Emergency, Casualty and Children's hospitals contract for care of certain tax-supported patients for the daily fee of $7.50. Doctors' Hospital charges $7.50 per day for ward beds; Georgetown, $7.50; Garfield, $7; George Washington, $6, and Emergency, $5. Freedmen's charges paying patients $7 per day for a private room.

Freedmen's, affiliated with Howard University, is a teaching institution as well as a hospital but this year the federal government has assumed all the additional expenses charged to Freedmen's teaching function.

Dr. George Ruhland, District Health Officer, has asked for $14,606,790 for the operation and improvement of Washington's two municipal hospitals—Gallinger and Glenn Dale Tuberculosis Sanatorium. Much of the increased appropriation is intended to increase the staff of Gallinger and make capital improvements of its plant.

Steer Raises Funds for Hospital

SAN FRANCISCO.—Something new in the way of raising hospital funds was undertaken this month when "Acacia," a 15 month old steer, was auctioned off by the Acacia branch of the Children's

Hospital of the East Bay, Oakland, Calif., November 4. Proceeds from the sale will be used to finance a new wing which will double patient capacity, to install an oxygen system and a premature nursery and to provide special facilities for polio and spastic patients.

Expand Children's Home

OKLAHOMA CITY, OKLA.—An expansion program for the Children's Convalescent Home here is planned to increase the capacity of the home from 33 to approximately 80 beds, it has been announced.

Rochester Announces Education Plan

ROCHESTER, N. Y.—Rochester General Hospital has announced details of a new educational program for general practitioners which has been approved by the hospital's medical board.

Purposes of the new program are to extend the professional facilities of the hospital as educational aids to general practitioners on the staff so that they can more readily acquaint themselves with new developments in medicine; to make educational opportunities available to general practitioners who are not on the hospital's staff, and to make hospital staff members more aware of community health needs.

The program which will be administered by the medical board, acting through specially appointed educational officers and committees, includes the following features:

1. Special training for general practitioners who intend ultimately to limit practice to one of the specialties.

2. A one year service period for practitioners intending to remain in general medicine.

It is expected that practitioners may avail themselves of additional years in other departments after completing this program.

"The educational program will be formulated by the respective chiefs of service for their individual services," the announcement said, "and it is suggested that insofar as possible the program be of a rotating nature. It is expected that staff members will be constantly available to assist participant practitioners in their programs."

N.U. Hospital Students Form Fraternity

CHICAGO.— Students in the Northwestern University hospital administration program have announced the formation of Alpha Delta Mu, the first Greek letter fraternity in the hospital administration field.

Purposes of the fraternity, according to its initial announcement, are to provide an official means whereby qualified hospital administrator students may add to their knowledge through the interchange of ideas and group discussions, special studies and authoritative lectures. A further purpose is to "assist in maintaining high morale and good scholarship among students and further to develop a common bond and spirit of fellowship." Officers of the fraternity are: president, John E. Paplow; vice president, Jack A. L. Hahn; secretary, James R. Gersonde, and treasurer, Herbert R. Rodde.

Membership is limited to students enrolled in degree courses and maintaining an academic average of B or higher.

The fraternity is interested in establishing chapters at other schools offering courses in hospital administration, it has been announced. "We welcome inquiries from other schools," Mr. Paplow said, "and will be glad to assist them in forming chapters of Alpha Delta Mu."

Some members who have already taken positions as administrators of hospitals have submitted practical problems for discussion by fraternity groups which then submit the best solutions worked out.

MacLean Heads Council

ST. LOUIS.—Basil C. MacLean, M.D., of the Strong Memorial Hospital, Rochester, N. Y., was elected president of the University Hospitals Executive Council at a meeting here last month. Gerhard Hartman, superintendent of University Hospitals at Iowa City, Iowa, was named secretary.

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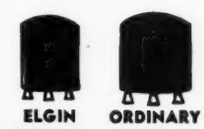

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Liberalize Requirements for Public Health Research Fellowships

WASHINGTON, D. C.—New and more liberal requirements for U. S. Public Health Service research fellowships were announced October 2 by Dr. Thomas H. Parran, surgeon general, U.S.P.H.S. Liberalizing these requirements is part of the national program to obtain an increased number of trained scientists urgently needed for essential research.

The fellowship program was formerly limited to holders of master's degrees. Now, students with bachelor's degrees may be eligible. In addition to tuition fees those with bachelor's degrees will receive stipends of $1200 if they have no dependents, $1600 if they have dependents. For holders of master's degrees, tuition fees will be paid plus $1600 for persons without dependents, $2000 for persons with dependents. Holders of doctor's degrees will get $3000 plus tuition fees if they have no dependents, $3600 if they have dependents.

Special fellowships can be awarded to holders of doctor's degrees who have also demonstrated outstanding ability or who possess specialized training for a specific problem.

Navy Assigns Mobile Surgical Units for Disaster Relief

WASHINGTON, D. C.—Highly mobile surgical units have been assigned to each of the 11 Naval Districts in the United States for use in disaster relief, the Navy Department announced October 14. The units are special automobile trailers, equipped with surgical facilities comparable to those of operating rooms of large hospitals. They contain the most modern anesthesia apparatus, oxygen tanks, surgical instruments and apparatus, blood, plasma, antibiotics and other facilities.

The normal complement of each trailer unit will be two navy doctors, one navy nurse, one anesthetist and two hospital corpsmen. A separate generator mounted on the trailer supplies electricity for surgery, lights, hot water and air conditioning and for operating instrument and dressing sterilizers.

The mobile units were lent to the Bureau of Medicine and Surgery by the Marine Corps which has agreed to their assignment to continental Naval Districts for use in disaster relief.

Plumbing Fixture Standards

WASHINGTON, D. C.—A pamphlet just released by the U. S. Department of Commerce through the National Bureau of Standards sets forth the latest standards for vitreous china plumbing fixtures, such as water closet bowls, tanks, lavatories, urinals and service sinks. It is entitled "Staple Vitreous China Plumbing Fixtures (Fourth Edition), Commercial Standard CS2C-47."

This edition of the standard brings it into line with the latest developments in the industry relating to faucet hole spacing, certain details of water closet and urinal design and colored ware. Flat rim sinks and flat rim laundry trays are also added to the group of items regularly available from suppliers. The revised standard is effective for new production from July 12, 1947. Copies are available from the Superintendent of Documents, Washington, D. C.

CORRECTION

L. O. Bradley, M.D., a graduate of the University of Chicago course in hospital administration, has been appointed associate professor in the department of hospital administration, school of hygiene, University of Toronto. In The MODERN HOSPITAL for October this appointment was incorrectly reported as having been made at the University of Montreal. There is no course in hospital administration at the latter institution.

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Cesarean Births Up; Hazards Lessened, Report Reveals

DETROIT.—The number of cesarean births has increased steadily over the last fifteen years and cesarean operations have become increasingly less dangerous, according to a statistical study made here by Dr. Harold C. Mack of Wayne University College of Medicine, president of the Michigan Society of Obstetricans and Gynecologists.

Dr. Mack recently completed a survey of cesarean operations in Detroit hospitals from 1930 to 1945, according to a report from the university.

In 1930, the report said, the ratio of cesarean births was one to 167. In 1945 the ratio was one to 37. In 1930, Dr. Mack found the death rate for cesarean operations was 4.43 per cent while in 1945 the rate was .8 per cent.

In his report, Dr. Mack attributed the greater safety of cesarean operations today to improved hospital organization, better operative technics and such factors as blood banks and penicillin.

In spite of the improvements noted, however, Dr. Mack warned that cesarean section is still five times more hazardous than normal delivery and must be employed only when there are positive indications pointing toward operation.

Reorganize N.Y.U. Nursing Department

NEW YORK.—Graduate nursing education at New York University has been organized into a separate department in the school of education, Dean Ernest O. Melby announced recently. Dr. Vera S. Fry, associate professor of education, has been named chairman-director of the department.

The department of nursing education offers a complete program in nursing subjects whereby graduate registered nurses may qualify for the degrees of bachelor of science, master of arts, doctor of philosophy or doctor of education, Dean Melby said. The program has been arranged to meet the need for adequately prepared staff, teachers, supervisors and administrators in all fields of nursing.

Hold Hospital Seminar

FORT WORTH, TEX.—The Texas Society of Architects held a seminar October 29 and 30 to discuss trends in hospital planning, effects of the Hospital Survey and Construction Act and other current problems affecting hospital architecture. The program included members of the architectural and hospital professions of Texas and national authorities in hospital planning.

Michael Reese Opens 70 Bassinet Nursery

CHICAGO.—A new 70 bassinet infant nursery, equipped with all the latest devices, including doors operated by an "electric eye," was opened at Michael Reese Hospital here October 22.

Among the modern features which make the nursery outstanding are:

1. Transparent cubicle walls separating each bassinet from its neighbors for the baby's protection.
2. Photo-electric cell control of doors from nursery to corridor, enabling nurses and others to enter and leave without touching the doors.
3. A "Dutch door" connecting the nursery and examining room used by pediatricians, so that physicans can examine infants without entering the nursery itself.
4. Complete air conditioning and acoustical treatment.
5. Intercommunicating system between nursery and mothers' demonstration room, permitting instruction to mothers without necessity for their entering the room where babies are kept.
6. Ultra violet ray air sterilization.
7. Separate isolation nursery.

Located on the third floor of the hospital, the nursery has an outside wall of glass brick, providing natural illumination in daytime. The project was financed by special gifts from the woman's board of the hospital and a few interested families in the community.

Administration Course Starts

WASHINGTON, D. C.—The army medical department starts its first class in hospital administration November 10 at Brooke Army Medical Center, Fort Sam Houston, Tex. The course will be of twelve weeks' duration and will be repeated at various intervals in the future. It is intended to qualify officers of the medical department to function efficiently in administrative positions within the army hospital system.

COMING MEETINGS

ASSOCIATION OF WESTERN HOSPITALS, Biltmore Hotel, Los Angeles, April 19-22.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Roanoke Hotel, Roanoke, Va., April 15, 16.

NEW ENGLAND HOSPITAL ASSEMBLY, Silver Jubilee, Hotel Statler, Boston, March 15-17.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Bellevue-Stratford Hotel, Philadelphia, April 28-30.

OHIO HOSPITAL ASSOCIATION, Deshler-Wallick Hotel, Columbus, April 6-8.

SOUTHEASTERN HOSPITAL ASSOCIATION, Biloxi, Miss., April 22-24.

TEXAS HOSPITAL ASSOCIATION, Dallas, March 4-6.

General Hospitals Should Establish Cancer Clinics—Goldman

CHICAGO.—Establishment of cancer detection clinics in connection with general hospitals was urged by Dr. Leonard B. Goldman of New York in an article appearing in the *Journal of the American Medical Association*.

Dr. Goldman described the cancer prevention and detection center now in operation at Queens General Hospital, Long Island, where he is a member of the staff.

"The public has been taught to seek medical advice at an early date and is now prepared for the preventive type of cancer control," Dr. Goldman said. "But many members of the medical profession are not equipped to give complete examinations necessary to rule out beginning cancer. Cancer has ceased to be a one man job, teamwork is essential. The most effective step for controlling this disease is to establish clinics."

Objectives of such clinics as summarized by Dr. Goldman include: (1) detection of early cancer; (2) prevention of cancer development; (3) education of patients, and (4) referral for proper treatment.

At the Queens Clinic a secretary and social worker take the patient's history; laboratory tests, including x-ray examinations, are then made, and patients are given thorough physical examinations. The professional staff includes a tumor specialist, internist, gynecologist, surgeon, otorhinolaryngologist and dermatologist.

Illinois Association Reorganizes Districts

CHICAGO.—Hospitals cannot afford to have more than 25 per cent of nursing personnel on the graduate nurse level in the future, Everett W. Jones, vice president of The Modern Hospital Publishing Company, told a meeting of the Illinois Hospital Association. Therefore, Mr. Jones said, hospitals would do well to spend more time and energy setting up short vocational training programs for nurse's aides and attendants and practical nurses, and less on recruiting qualified students for registered nurse training.

A new district organization for the Illinois association was announced by Evelyn Johnson, administrator of the Brokaw Hospital, Normal, who is chairman of the association's relations committee. District chairmen in the new regional organization are:

District 1, Dr. Roger W. DeBusk, Evanston.
District 2, Orville Peterson, Aurora.
District 3, Harry D. Keller, Freeport.
District 4, J. T. Tollefson, Moline.
District 5, Dr. C. S. Woods, Peoria.
District 6, Evelyn Johnson, Normal.
District 7, Marguerite Kaelberer, Mattoon.
District 8, H. R. Haupt, Decatur.
District 9, J. F. Tubergen, Alton.
District 10, Dr. G. H. Van Dusen, East St. Louis.

Study Social Security Program

WASHINGTON, D. C.—Chairman Millikan of the Senate Finance Committee appointed a 17 man council September 28 to make a careful scrutiny of all aspects of the Social Security program. The group will be headed by former Secretary of State Edward Stettinius. Existing programs under the Social Security Act will be studied and recommendations for needed changes including broader coverage will be made. The House Ways and Means Committee a couple of years ago made an exhaustive survey of the entire Social Security program. Although a lengthy report, known as the "Calhoun Report," covering all available data, together with recommendations for changes, was brought out, no fundamental revisions were made as a result of the study.

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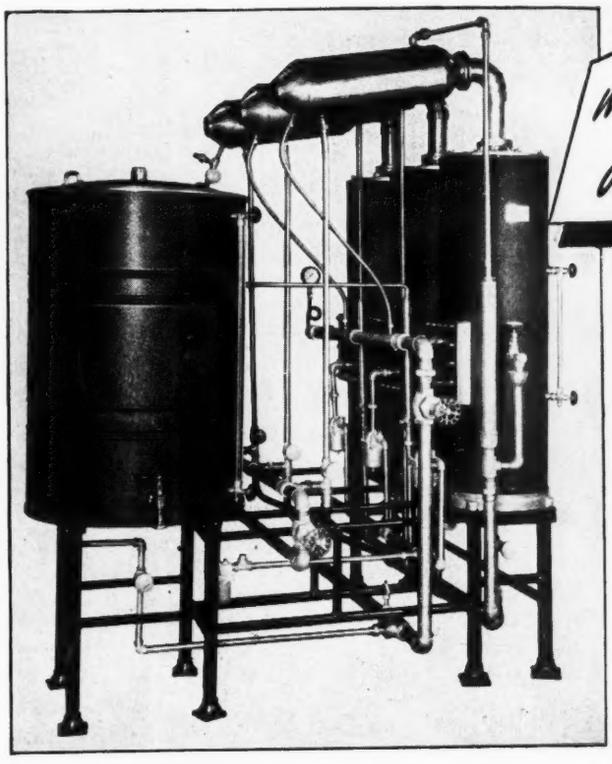

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Hospital Accountants Form National Group

ROCHESTER, N. Y.—Formation of the American Association of Hospital Accountants to advance uniformity and efficiency in hospital accounting was announced last month by Helen M. Yerger, assistant administrator at Park Avenue Hospital, Rochester, and public relations director of the new association.

Purposes of the organization as outlined by Miss Yerger are:

1. To promote closer cooperation among hospital accountants in advancing uniformity and efficiency in hospital accounting.
2. To encourage and assist members to increase their technical knowledge of hospital accounting.
3. To provide a medium for the interchange of ideas and dissemination of hospital accounting material.
4. To encourage meetings and conferences of hospital accountants.

Officers of the new association are: president, Frederick T. Muncie, C.P.A., Chicago; first vice president, Percy F. Riggs, Hollywood Presbyterian Hospital, Hollywood, Calif.; second vice president, Percy Ward, Vancouver, B. C.; secretary-treasurer, William G. Follmer, Rochester Hospital Council; directors, William F. Voboril, Boston; William A. Dawson, Baltimore; Stanley A. Pressler, Bloomington, Ind.; Graham L. Davis, Battle Creek, Mich.; M. Ray Kneifl, St. Louis; James C. Brady, Ottawa, Canada.

The first issue of the association's bulletin was distributed last month, Miss Yerger said. The association was formed after an extensive survey of hospital accountants in various parts of the United States and Canada indicated the need for such a group, it was explained.

Propose $16,000,000 for Army Library

WASHINGTON, D. C.—Congress will be asked next year to renew authorization for a new army medical library here to cost an estimated $16,000,000, according to the acting surgeon general, Brig. Gen. George L. Armstrong, in a statement October 10. General Armstrong made the statement before the fourth annual meeting of the honorary consultants to the army medical library.

The acting surgeon general said that in 1938 Congress authorized plans for a new building to cost $3,750,000. Estimates were up to $10,000,000 by last year and now are about $16,000,000. It will be necessary for Congress to amend the enabling legislation before an appropriation can be requested. Increased construction estimates are due partly to spiraling building costs and partly to plans for expanding the library.

Army Sets Standards for Internships and Residences in 1948

WASHINGTON, D. C.—Two hundred medical and 50 dental internships will be offered by the army in 1948 to be filled by recent medical and dental school graduates, it was learned at the office of the surgeon general October 15. There will also be 350 fully approvel residencies for periods of one, two and three years, depending upon the specialty desired and previous experience of candidates in various army general hospitals. The internships will be for one year.

To meet the qualifications required for medical interns, an applicant must be a male graduate of a medical school approved by the Council on Medical Education and Hospitals of the A.M.A. He must also be eligible for appointment as a medical officer in the officers' reserve corps of the army. Graduates of foreign schools are not eligible.

An applicant as dental intern must be a citizen of the United States; a graduate of an approved dental school (now completing fourth year of dental training); not more than 30 years of age on July 1, 1947. He must have made no agreement to accept an internship appointment in any other institution and he must be able to meet the physical standards for appointment in the dental corps of the regular army.

Qualifications required for residents are: they must be regular army medical officers or applicants for the regular army who are graduates (male) of an approved medical school. Applicants must be eligible for appointment as medical officers in the officers' service corps of the army. They must also have completed at least one year of rotating internship in a hospital approved by the Council on Medical Education and Hospitals of the A.M.A. They may receive appointments as assistant resident, resident or senior resident, according to their professional background. Graduates of foreign schools are not eligible.

Urges Continuing of Planning Program

WASHINGTON, D. C.—Continuation of a national program of federally-financed advance planning for local public works was advocated by Federal Works Administrator Fleming in a talk October 2 at a meeting of the Producers Council in New York City. The advance planning program of the Bureau of Community Facilities, terminated June 30, put $65,000,000 into an estimated $2.3 billion backlog of public construction. Close to four million of the sixty-five went into advance planning of hospitals.

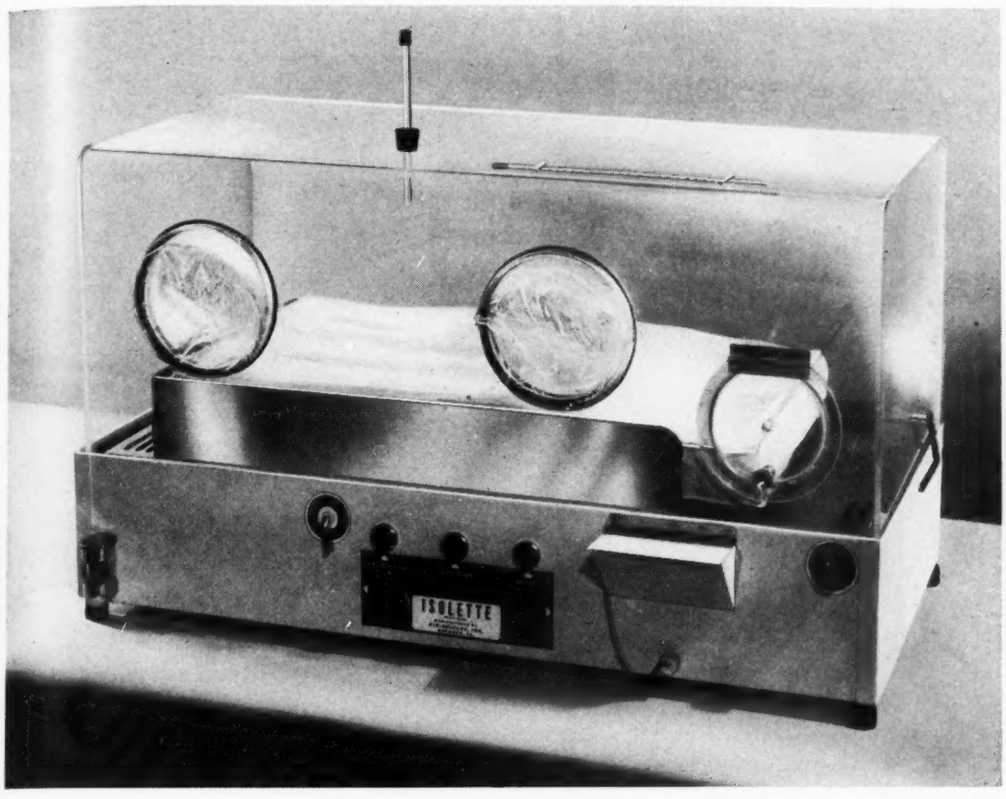
"You don't push a button and speed up the assembly line to produce schools, hospitals and roads," General Fleming said. "Each project is designed and tailored to fit a particular need of a community, at a particular site, at a particular moment. It takes a long time to design and engineer these structures."

A bill to continue the advance planning program was by-passed in the first session of the 80th Congress. The proposal encountered no opposition. It simply got lost in the final rush for adjournment.

Start Joint Purchasing Plan

PHILADELPHIA.—A joint purchasing program for hospitals will be sponsored by the Hospital Council of Philadelphia which has organized the Hospital Purchasing Service of Pennsylvania, according to an announcement made by the council last month. Voluntary hospitals may become active members of the service, it was explained, and other welfare agencies may be included as associate members. Donald S. Reams, purchasing agent for the mental and nervous department of Pennsylvania Hospital, was named general manager of the new service, the announcement said.

THE ISOLETTE



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- The transparent plastic dome remains closed at all times, thereby excluding droplets and preventing inadvertent contact.
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N. Y. State Nurses Favor Social Security

NEW YORK.—Social security protection for nurses was favored in a resolution adopted by the New York State Nurses' Association at a meeting here last month. "There is no reason nurses should be discriminated against with respect to social security coverage," the resolution declared, requesting that the American Nurses' Association seek legislation providing social security coverage for its members.

Public support looking toward "a living wage and desirable working conditions" for nurses was requested by Clare M. Casey of New York, president of the state association, in an address made at an open session of the convention. Miss Casey said public help was also needed to recruit qualified students, maintain adequate nursing schools and provide scholarships for worthy students. Miss Casey urged nurses to combat "claims that we have become callous in our attitude toward patients." The vast majority of nurses, she maintained, had a "deep and abiding concern" for the welfare of the sick.

Elizabeth C. Phillips, president of the New York City district organization, emphasized the need for independent thinking by nurses on controversial issues affecting the profession. Miss Phillips pointed out that nurses generally have followed policies adopted by the medical profession.

Expand V.A. Clinics in New York Area

NEW YORK.—Expansion of Veterans Administration mental hygiene clinics in the Greater New York area was announced last month by Joseph F. O'Hern, deputy V.A. administrator in New York. The increase in clinic facilities will result in substantial savings for the Veterans Administration, Mr. O'Hern said. He pointed out that V.A. is now spending more than $2,000,000 annually for payments to private psychiatrists on a fee basis and that the expanded clinic program would make the same volume of care possible at a cost of $1,000,000 a year.

"Psychiatric care, second to none, can be rendered under clinic conditions where the services of a psychologist and psychiatric social worker are available," Dr. Nils B. Hersloff, chief of the neuropsychiatric service in New York, said. "About 25 per cent of the case load carried on an outpatient basis by the adjuncts to a psychiatrist would otherwise be in neuropsychiatric hospitals."

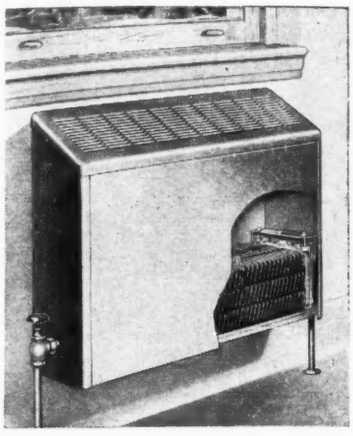
The clinic program will emphasize a team approach aimed at prevention as well as psychiatric treatment, it was explained.

Bush Heads Research

WASHINGTON, D. C.—Dr. Vannevar Bush was named to one of the top jobs in the new Office of National Defense September 25 when President Truman appointed him as chairman of the Research and Development Board. The board will have a civilian chairman and two members each from the army, navy and air force. Dr. Bush, one of the creators of the atom bomb, has headed the temporary Research and Development Board jointly established last year by the army and navy. He is also president of the Carnegie Institution, scientific research organization.

Homeopaths Hold Meeting

WASHINGTON, D. C.—Latin-American and Canadian doctors along with their colleagues from the United States held a joint session here of the Pan American Homeopathic Medical Congress and the Southern Homeopathic Medical Association October 2-4. The three day conference ended with a special tribute to the memory of Samuel Christian Friedrich Hahnemann.



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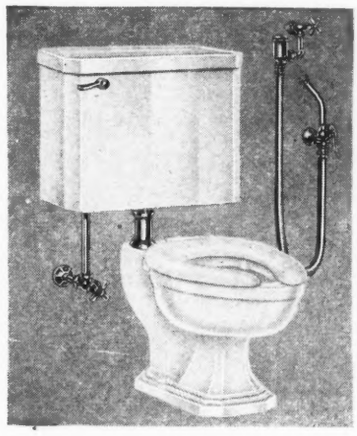

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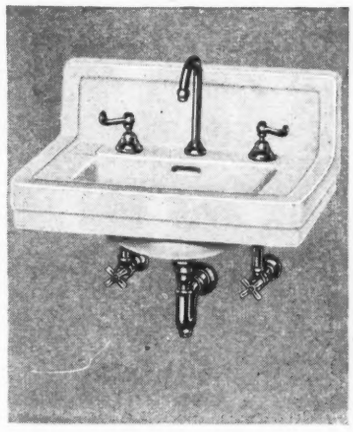

VITREOUS CHINA LAVATORY for private or semi-private rooms and treatment rooms. Gooseneck spout, wrist control faucets and roomy square bowl make it ideal for use by attending physicians. Wall hung to keep floor area clear. Cast-in soap dish is an added convenience.

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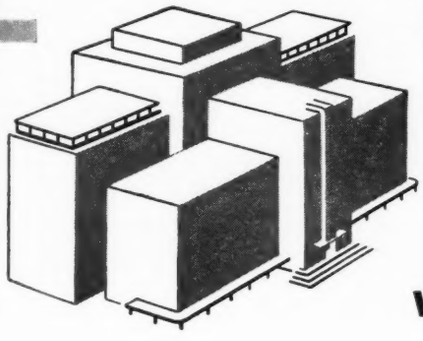

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Army Sets Up First Affiliated Hospital Unit at U. of Texas

WASHINGTON, D. C.—The University of Texas has sponsored the first affiliated unit of the army medical department's postwar affiliated program, an official of the surgeon general's office revealed in an interview October 15. The school has agreed to sponsor a 1000 bed general hospital. Additional units, both general and evacuation hospitals, from other leading medical schools and hospitals will be activated this year.

The professional members of these new hospital units will be drawn from the faculties and staffs of the medical schools and hospitals which sponsor them. The personnel will be trained in army methods and procedures so that in the event of mobilization these units will be prepared to take the field without delay.

In World War II there were 73 affiliated units, comprising general, evacuation and portable surgical hospitals. The medical branch of the University of Texas sponsored a general hospital—the 127th General Hospital.

V.A. Starts Program of Radioisotope Study

WASHINGTON, D. C.—A limited research program into the use of radioactive isotopes for diagnosing and treating certain types of diseases afflicting veterans was announced by the Veterans Administration October 7. The program will be carried on during the next year at six V.A. hospitals. At each hospital, research will be conducted under the supervision of prominent scientists from nearby universities participating in the V.A. medical program.

Dr. George M. Lyon of Huntington, W. Va., as chief of V.A.'s Radioisotope Section, will be in charge of the program. A central advisory committee on radioisotopes has been appointed to advise V.A. in matters of policy and planning. The committee includes some of the nation's foremost authorities in medical research. Three of the members are particularly expert in the medical problems of nuclear fission.

Pratt Hospital Adds Floor

BOSTON.—Joseph H. Pratt Diagnostic Hospital, a unit of the New England Medical Center, has announced the opening of the third floor of the hospital for patient occupancy. Previously used for other hospital purposes, this additional space for patients in the rapidly growing institution provides 31 beds, bringing the total number to 84.

Indiana Inaugurates Long Range Program of Nurse Recruitment

EVANSVILLE, IND.—A long range program to interest young women in becoming nurses is planned by a joint committee on nursing of the Indiana Hospital Association and the Indiana State Nurses' Association, hospital officials have reported. The program will include visits to state high schools to inform principals and vocational counselors about nursing careers. Nursing representatives will also attend state teachers' meetings to discuss the requirements for nursing school candidates.

The committee also urged that the hospital association undertake a study of operating costs in nursing schools throughout the state. The study should also cover an analysis of the time student nurses spend in classes, practice training and actual hospital work, the committee suggested.

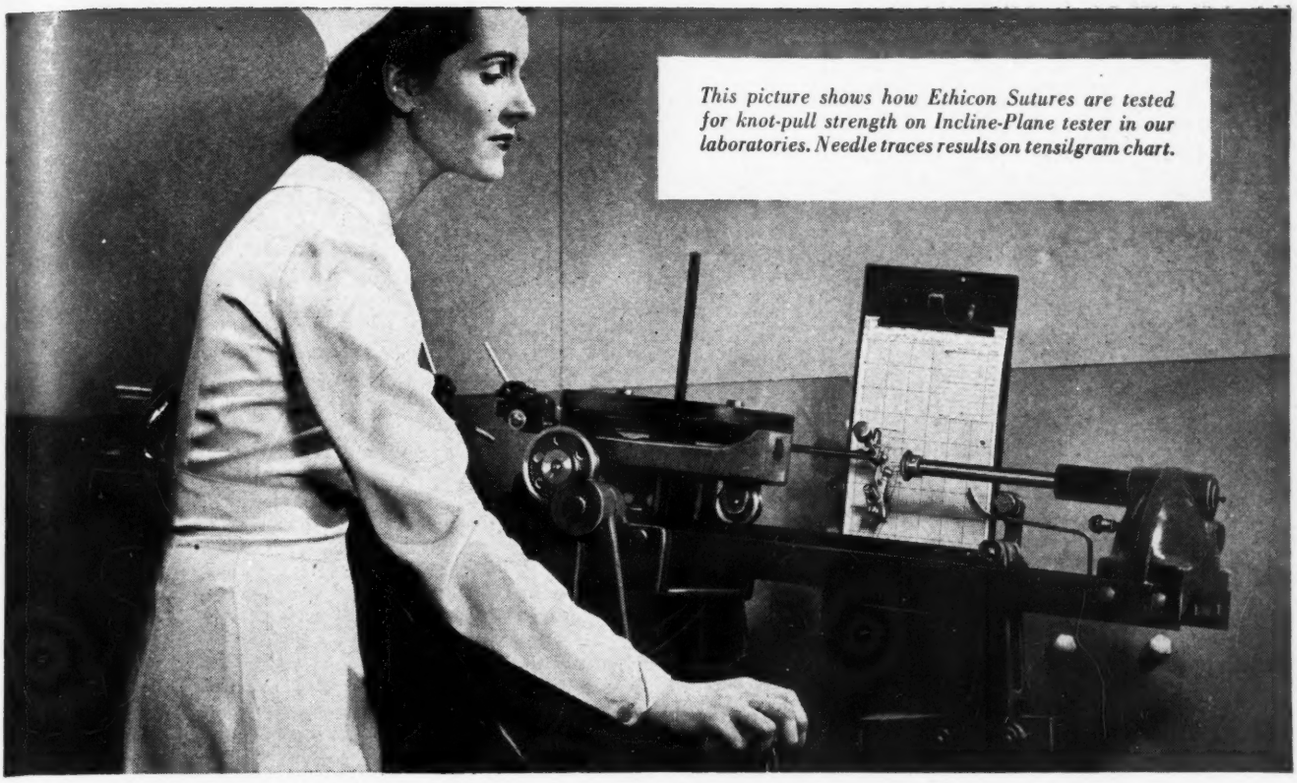
J. Milo Anderson of the Methodist Hospital, Gary, was named chairman of a special committee organized to carry out a concerted program of nurse recruitment in cooperation with the nurses' association. Other members of the committee are Crayton E. Mann, Welborn Memorial Baptist Hospital, Evansville; Sister Vincentiana, St. Elizabeth's Hospital, Lafayette; Ella Mae Doty, Memorial Hospital, South Bend; John M. King, Reid Memorial Hospital, Richmond; James Waggener, Blue Cross Hospital Service, Indianapolis.

Florida Gets Army Installations for Use as Hospitals

WASHINGTON, D. C.—Three wartime army installations are being transferred to the state of Florida for use as hospitals, Maj. Gen. Philip B. Fleming, Federal Works Administrator, announced October 1. The installations comprise buildings and an aggregate of 2525 acres of land.

The reservations are Dorr Field, consisting of 1527 acres; Carlstrom Field, 853 acres, both near Arcadia, Fla., and the hospital area of the Marianna Army Airfield at Marianna, covering 145 acres. The two former air fields will be made a branch of the State Hospital at Chattahoochee. The added buildings will accommodate about 1500 patients suffering mild mental illness.

The hospital area of the Marianna Army Airfield was deeded to the State Tuberculosis Board of Florida to be used as a 300 bed sanatorium. One half of the number of beds will be allocated to the Veterans Administration for the treatment of former service men and women; the other half will be used for civilians.



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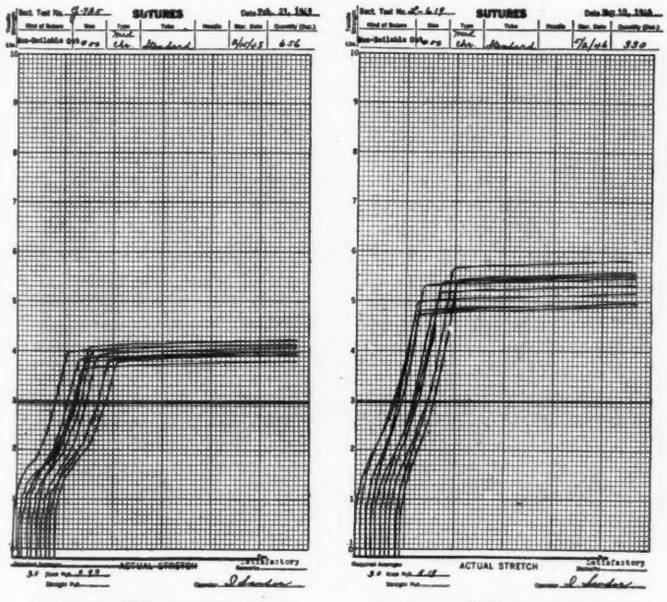

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Masons Establish Foundation to Study Rheumatic Fever

NEW YORK.—Establishment of a foundation to support research in the causes and therapy of rheumatic fever was announced last month by the Masonic Grand Lodge of the state of New York. The Masonic order will immediately undertake a fund raising campaign among its members in New York State to support the new program, the announcement said, but resources of the fund will be available to all regardless of affiliation or location.

In spite of the enormous difficulties encountered in rheumatic fever, less money is spent on the solution of this problem than on any other major disease, Dr. Currier McEwen, dean of New York University Medical College, stated in connection with establishment of the fund. In addition to high mortality rates from the disease, Dr. McEwen added, more time is lost from work because of rheumatic fever and arthritis than from accidents or any other disease.

Announce Building Fund Appeal

HANOVER, N. H.—A major building fund appeal to finance an extensive, long range expansion program for Mary Hitchcock Hospital has been announced here. The program calls for erection of a new clinic building, a nurses' home, an education building and addition of two wings to the main hospital building to house at least 150 additional beds. Patients are now being cared for in corridors and sun parlors, and the bed shortage is acute, an announcement by the hospital board stated.

Stress Ethics in Selecting Students, Hawley Urges

WASHINGTON, D. C.—Establishment of ethical as well as academic requirements in the selection of students entering medical school was urged by Maj. Gen. Paul R. Hawley, medical director of the Veterans Administration, in an address last month at a meeting of army medical library consultants. General Hawley advocated this method of "taking the rascals out of medicine."

Under the present system, he said, we have no way of eliminating those who are exploiting medicine after the early years of medical school. Therefore, he said, he favors a system setting up high ethical standards for medical school applicants.

"Medicine is at the cross roads," General Hawley declared. "We must decide now to take it away from those who would exploit it."

Offers Medical Service Plan

PITTSBURGH.—Hospital Service Association, Pittsburgh Blue Cross, will offer its member groups the surgical and medical plans sponsored by the Medical Service Association of Pennsylvania, it was announced last month. Blue Cross will act as the agent of the medical service group in offering Blue Shield medical and surgical plans in the 29 western counties of the state, according to the announcement by Dr. J. A. Daugherty, president of Medical Service, and Abraham Oseroff, vice president and secretary of Blue Cross.

To Run Clinton Laboratory

OAK RIDGE, TENN.—The Clinton Laboratories have been renamed Clinton National Laboratory and will be operated henceforth by the University of Chicago for the Atomic Energy Commission, it was announced last month. A contract is now being made which will permit the university to take over operation of the laboratory from Monsanto Chemical Company which has managed it for the last two years, it was explained. The laboratory is one of several facilities operated by the Atomic Energy Commission at Oak Ridge.

Hospitals to Comply With Food Program

CHICAGO.—Following announcement of the national voluntary food conservation program in Washington last month, the American Hospital Association issued a statement urging hospitals to observe meatless Tuesdays and poultryless and eggless Thursdays in accordance with the President's wishes, excepting only instances in which compliance would be contrary to the nutritional and dietary requirements of hospital patients.

"Compliance with the President's request should be possible insofar as meals to hospital personnel and routine food service to patients are concerned," the statement by Graham L. Davis, association president, said. "However," he added, "the special diet requirements of patients must necessarily follow the physicians' recommendations in the interest of proper patient care."

The association's policy of cooperation in the food program was condemned by the *Chicago Tribune* in an editorial appearing October 13. Referring to the announced intention of a group of restaurant owners to leave food conservation "up to the customers," the *Tribune* said, "This is a refreshing contrast to the recommendation by the sycophantic fatheads of the American Hospital Association that hospitals deny sick people normal nourishment in order to go along with this New Deal press agent stunt."

A survey of several hospitals made by The MODERN HOSPITAL in connection with the food program indicated that most administrators are following the President's suggestion and the stated association policy. In Washington one administrator told a MODERN HOSPITAL reporter, however, that "hospitals can make little more than a gesture toward food conservation."

Another administrator expressed the opinion that hospitals should conserve food in every way possible but refrain from making any public announcement on the subject.

A.H.A. Institute on Hospital Planning

CHICAGO.—An institute on hospital planning will be conducted by the American Hospital Association in Chicago December 1 to 5 to give administrators and other hospital officials background information on hospital planning and construction.

Advance organization, general planning, patient and service areas and planning and building details are the general areas of discussion. Specific topics include the shape of the hospital, elasticity and provision for future expansion, nursing and patient requirements, fire safety and explosion-proofing, choosing the architect, planning the kitchen and food distribution, laundry, power plant, laboratories and placement of special departments.

One session will be devoted to a discussion of the Federal Hospital Survey and Construction Act, how to survey community needs and the number of beds required. Cost of building and methods of financing costs will also be discussed.

Study Medical Aspects of Atomic Explosion

WASHINGTON, D. C.—A third class on November 3 began the course in "Medical Aspects in Atomic Explosion" conducted here at the Army Medical Department Research and Graduate School, Army Medical Center. The five day course is given to orient medical officers of the army, air force, navy and public health service and doctors of the Veterans Administration in the fundamental principles of this subject.

Two classes in this course were conducted here previously in May and September. It is planned to repeat the course each month until the majority of doctors have been indoctrinated.

Name Winners of Education Contest

CHICAGO.—Winners of awards in the annual public education contest sponsored by the Illinois Hospital Association named at an association meeting last month were Geneva Community Hospital, Geneva, first place among hospitals of 100 beds or less; Silver Cross Hospital, Joliet, first place among hospitals of 100 to 200 beds; St. Francis Hospital, Evanston, first place in hospitals of 200 to 400 beds; St. Luke's Hospital, Chicago, first place among hospitals of more than 400 beds; Children's Memorial Hospital, Chicago, first place for special hospitals regardless of size.

Newspapers honored for their records in presenting information in the interest of hospitals were the *Joliet Herald News* and the *Geneva Republican.*

In addition to the winners, merit awards were given to Deaconess Hospital, Freeport, and Marshall Browning Hospital, DuQuoin, in the small hospital group; Cottage Hospital, Galesburg, and Little Company of Mary Hospital, Evergreen Park, in the 100 to 200 bed classification; Grant Hospital, Chicago, in the 200 to 400 bed group and, among special hospitals, St. John's Hospital of Springfield, Chicago State Hospital and the Veterans Administration Hospital at Hines.

The awards will be presented during the midyear conference of the Illinois association to be held in December or January, it was announced. Members of the judges' committee which reviewed scrapbooks, house publications and other material submitted were: C. Norman Andrews, assistant director, Chicago Blue Cross; Ruth Brannon, director of public relations, Chicago Blue Cross, and E. E. Salisbury, director of the Chicago Hospital Council.

U.S.P.H.S. Awards Funds for Cancer Research

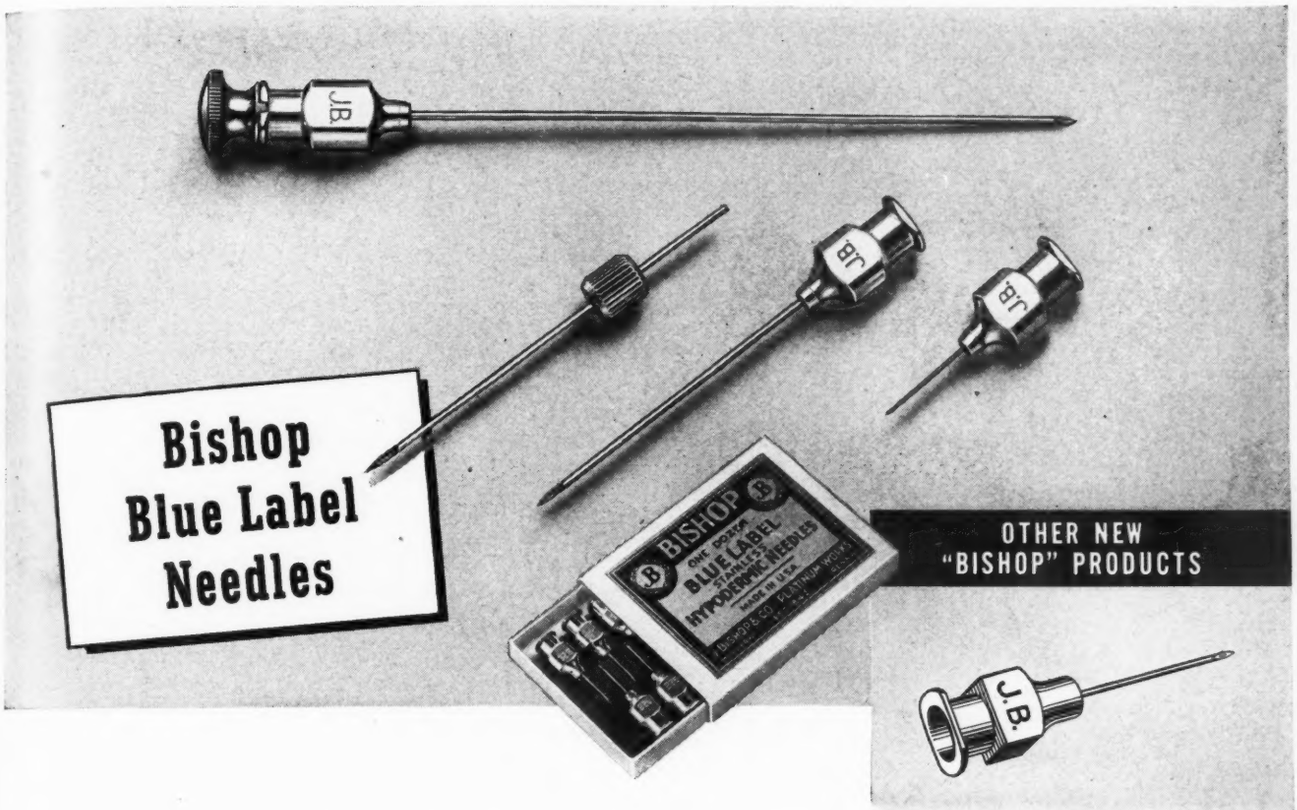
WASHINGTON, D. C.—Award of $375,000 in Public Health Service grants for cancer research and study was announced in a report made public October 8 by Dr. A. V. Deibert, chief of the cancer control subdivision of the National Cancer Institute. The awards, reviewed and approved by the National Advisory Cancer Council, are part of the 14 million dollar cancer research and control program voted by Congress for the current fiscal year.

These grants will finance research on improved technics for professional cancer instruction; a nationwide survey of cancer clinics, and evaluations of various cancer control measures.

Cornell University lead off with the largest grant of $37,800 for the establishment of a center for the study of and instruction in the cystologic test for cancer. The American Cancer Society came next with a grant of $36,600 for a cooperative project for the production of diagnostic motion pictures. The American College of Surgeons received $30,340 for a survey of cancer clinics throughout the country.

Refresher Course for V.A. Cooks

WASHINGTON, D. C.—Chief cooks in 18 Veterans Administration hospitals in New England and New York State recently completed a four weeks' refresher course in food service, according to a V.A. announcement October 27. They learned how to replace assembly-line feeding technics in hospital cafeterias with more informal home-like procedures. The course stressed a new method of meat cutting to ensure tastier, more attractive looking portions. The method, "on-the-line" carving, consists of slicing meat in front of the patient during mealtime, rather than cutting it in the kitchen several hours in advance. The culinary experts were taught how to prepare the meat in smaller uniform sizes to allow for easier handling by cafeteria attendants who slice it for the patients.



To most physicians who were in military service, Bishop "Blue Label" Needles are already familiar and trustworthy friends. Their unusual ability to perform *well*, even under the most adverse conditions, has been proved beyond all question by the millions of "Blue Label" Needles supplied to the armed forces before and during World War II. Bishop now makes available to civilian doctors and institutions as well, these same "Blue Label" Needles, unsurpassed for keenness and resistance to breakage, with the special hand-finished Bishop point—ideal for every hypodermic needle use.

Available, through your regular source of supply, in a complete line of standard lengths and gauges. Write today for booklet describing Bishop "Blue Label" Needles and the other products illustrated at the right of the page. **Medical Products Division, J. Bishop & Company Platinum Works, Malvern, Pa.**

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OTHER NEW "BISHOP" PRODUCTS

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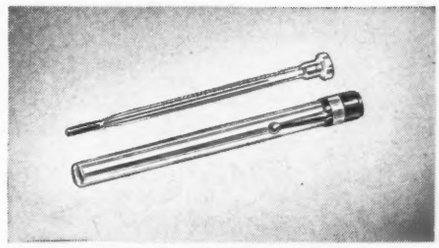
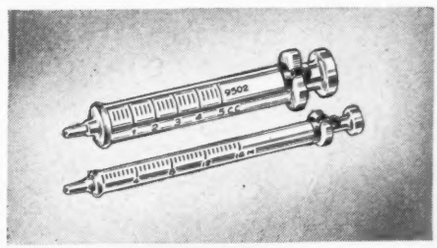


BLUE LABEL CLINICAL THERMOMETERS—Accurate—sturdy—easily read.



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*Pat. applied for.

SERVICE TO SCIENCE AND INDUSTRY SINCE 1842

County Buys U. S. Hospital

WASHINGTON, D. C.—Prince George's County Commissioners were authorized to buy the Prince George's General Hospital from the federal government October 14 for the sum of $150,000. The hospital will be operated as a county hospital in the same manner as at present except that the county will have title to the property. Holding title to the property will enable the commissioners to proceed with plans for construction of a 110 bed wing for Negro patients, and a public health center.

The hospital was constructed in 1942-43 at a cost of approximately $750,000.

ABOUT PEOPLE

(*Continued From Page* 84.)

Miss Ashby Taylor, for the last thirteen years director of nursing at Children's Hospital, Washington, D. C., resigned October 1 to begin "a little rest" from her nursing duties. She does not expect to leave the nursing profession permanently. As president of the Graduate Nurses' Association of the District of Columbia, she will continue to take an active part in the formulation of policies for the nursing profession. **S. Kathryn Witmer,** formerly director of nursing at Milford Memorial Hospital, Milford, Del., is taking the place vacated by Miss Taylor.

Mrs. Lucile F. Palmer has been named social service director of Newton-Wellesley Hospital, Newton Lower Falls, Mass. Mrs. Palmer, a member of the American Association of Medical Social Workers and formerly with the social service department at the Boston Dispensary, succeeds **Elizabeth F. Wheeler** who is retiring.

Dr. Alexander Brunschwig, formerly professor of surgery at the University of Chicago, has assumed a new post as department head at Memorial Hospital, Center for the Treatment of Cancer and Allied Diseases, New York, with the concomitant appointment as professor of clinical surgery at Cornell University Medical College.

Elizabeth Smith has resigned her position as director of the school of nursing and nursing services at Concord Hospital, Concord, N. H.

Miscellaneous

Alberta M. Macfarlane, educational director of the National Restaurant Association, is supervising the planning, preparation and distribution of special meat planning information of the consumer service section of the Citizens' Food Committee. **Margaret Gillam** of the American Hospital Association is a member of the same committee.

Antone G. Singsen has been appointed assistant director of the Blue Cross Commission of the American Hospital Association. Prior to joining the commission staff in January 1946 Mr. Singsen had been public relations director of the Rhode Island Blue Cross plan in 1939-41 and of the Connecticut plan in 1941-43. For a period during the war he also served as public relations consultant of the Blue Cross plan located at Sioux City, Iowa.

Lawrence C. Wells has been named public relations manager for the Blue Cross Commission, it was also announced in October. Mr. Wells joined the commission's public relations staff a year ago as supervisor of publications. Since that time he has served as assistant and acting public relations manager before being named head of this division of the commission.

Dr. Thomas Parran, surgeon general of the United States Public Health Service, received the special award offered annually by the Albert and Mary Lasker Foundation in recognition of contributions toward the health of the nation. Dr. Parran's award, which included $2500 and a gold statuette, was presented for his campaign to break the

prejudice against the use of the term "syphilis," which led to the establishment of rapid treatment centers.

Dr. Richard J. Plunkett has assumed the duties of associate editor of the *Journal of the American Medical Association.* He was formerly vice president and director of the Division of Health and Sanitation of the Institute of Inter-American Affairs, Washington, D. C.

Lt. Col. Mary G. Phillips has been named chief of the army nurse corps with the rank of full colonel to succeed **Col. Florence A. Blanchfield.** Col. Phillips entered the army nurse corps in 1929. She served during World War II as deputy superintendent of the A.N.C., Office of the Surgeon General, and later as director of nurses, Pacific Theater of Operations.

Dr. Paul B. Magnuson, noted surgeon and former chairman of the department of bone and joint surgery at Northwestern University Medical School, has been named acting chief of Veterans Administration professional services, succeeding **Brig. Gen. Elliott C. Cutler.** Dr. Magnuson joined the staff of the Veterans Administration in November 1945 on six months' leave of absence from Northwestern to assist **Dr. Paul R. Hawley** in reorganizing medical care for veterans. He has been with the V.A. since as acting chief of the research and education service. He will be succeeded in that capacity by **Dr. Edward Harvey Cushing,** former associate clinical professor of medicine at Western Reserve University, Cleveland.

William Harding Jackson, president of the Society of the New York Hospital, New York City, was elected chairman of the Hospital Council of Greater New York at the annual organization meeting of the council's planning committee. Mr. Jackson is also chairman of the current campaign of the United Hospital Fund. Other officers of the hospital council named at the meeting are: vice presidents, **Very Rev. Msgr. John J. Bingham,** director, Division of Health Catholic Charities, Archdiocese of New York; **Norman S. Goetz,** president of the Federation of Jewish Philanthropies, and **John H. Hayes,** director of Lenox Hill Hospital and recent president of the A.H.A.; treasurer is **Mrs. Adrian Van Sinderen** of Brooklyn.

Dr. Kendall Emerson, managing director of the National Tuberculosis Association since 1928, has announced his resignation effective January 1. He will be succeeded by **Dr. James E. Perkins,** deputy commissioner of the New York State Department of Health.

Duraclay *
on the job at Methodist Hospital

The picture tells the story of Crane Duraclay. Look at these Duraclay fixtures long on the job at Methodist Hospital, Gary, Indiana, and you will see the same immaculate gleam that was there the day they were installed. Here are the reasons why:

1. Duraclay is highly resistant to thermal shock . . . sudden changes in temperature do not crack or craze its gleaming surface.
2. It will withstand abrasion, is not affected by chemical preparations, alkali or acids.
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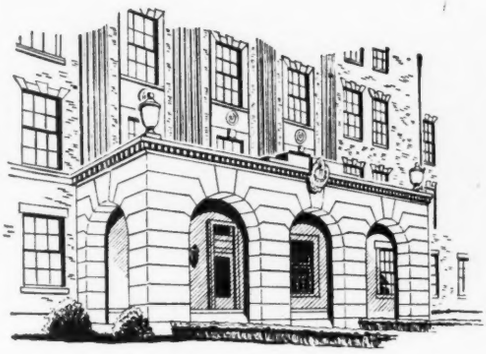

In Methodist Hospital, as in leading institutions throughout the country, fixtures of Crane Duraclay have long withstood the most exacting service required of any plumbing fixtures.

Scene in Methodist Hospital, Gary showing Flushing Rim Service Sink and Pack Tray, both of Crane Duraclay.

* ***Duraclay*** *exceeds the rigid tests imposed on earthenware (vitreous glazed) established in Simplified Practice Recommendation R106-41 of the National Bureau of Standards. In remodeling or extending your plumbing facilities, be sure to specify Crane Duraclay.*

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Maj. Gen. Norman T. Kirk, U. S. Army, Retired, former surgeon general of the army, was awarded the Gold Key of the American Congress of Physical Medicine at its annual meeting in Minneapolis in September. The award is made annually to prominent figures in the international field of medicine who have contributed toward the advancement of the specialty of physical medicine. The citation in part read "the establishment of physical medicine as a major medical service in the army was accomplished because of the personal efforts of Doctor Kirk." Others to receive the Gold Key at this time were **Lord Thomas Jeeves Horder,** physician to His Majesty the King of England and president of the British Association of Physical Medicine, and **Dr. Andrew C. Ivy,** vice president of the University of Illinois, consultant to the Council on Physical Medicine of the American Medical Association and special consultant to the Secretary of War regarding war crimes of a medical nature.

Deaths

Dr. Emanuel Giddings, medical superintendent of Kings County Hospital, New York, died September 25 at the hospital. Dr. Giddings, who served the municipal hospital department of New York City for thirty-six years, was 61 years old. He was a nationally known authority in the hospital field and the author of numerous papers on various phases of hospital operation. Dr. Giddings was assistant director of Mount Sinai Hospital for a brief period early in his career. After joining the municipal hospital department in New York he served at the Willard Parker Hospital, Riverside Hospital, Bellevue and Morrisania hospitals before becoming superintendent of Kings County.

The BOOKSHELF

WHY WE NEED MORE HOSPITALS
WHAT IS A HOSPITAL SYSTEM?
HOSPITAL SURVEY AND CONSTRUCTION PROGRAM
HOSPITAL QUIZ

These four pamphlets have been prepared by the Hospital Facilities Division, U. S. Public Health Service, for the assistance of hospital people and interested public officials and private citizens of communities where additional hospital facilities are or may be needed.

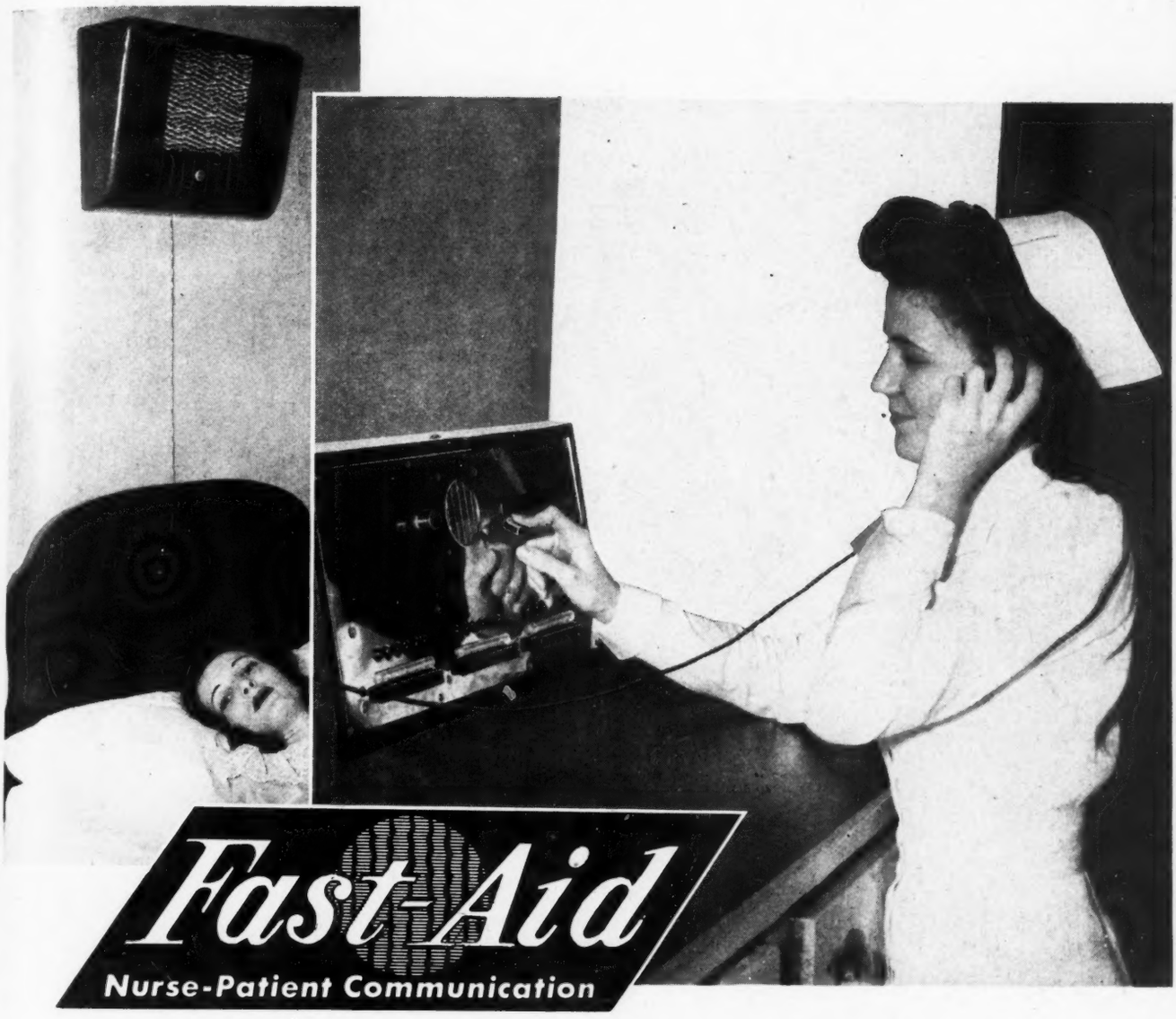
"Why We Need More Hospitals" summarizes the national hospital situation as revealed in the Commission on Hospital Care survey, indicating the uneven distribution of existing facilities and outlining the general needs for additional beds and services, especially in rural areas.

"What Is a Hospital System?" explains how a coordinated program of community clinics and hospitals, regional or district hospitals and base medical centers would operate and what advantages such a system offers over the present uncoordinated facilities.

"Hospital Survey and Construction Program" is a summary of the provisions of Public Law 725 and the regulations which have been developed in the administration of the law, governing construction projects to be financed with government assistance.

"Hospital Quiz" tells in question and answer form how the federal hospital survey and construction program works and what communities should do to fit their needs into the survey, planning and building program at various stages.

These booklets are to be distributed through district offices of the U. S. Public Health Service, it is explained. Sample copies may be obtained free of charge at these offices, in limited quantities. Copies for bulk distribution may be obtained from the Government Printing Office. The booklets are multigraphed and have from 8 to 12 pages each.



The Shortest Distance Between Nurse and Patient

You can have the best possible system of nurse-patient communication, saving time, money, work, and nurses—and giving better service.

With Fast-Aid, your nurse at the chart desk can talk directly with the patient and the patient can talk with her. Fast-Aid cuts down on the number of trips each nurse must make.

And patient-relations benefit. Surveys show that a big complaint among patients is that signal lights are not answered promptly. With Fast-Aid, a highly sensitive, two-way speaker-microphone in each patient's room picks up everything the patient says once he has signalled the desk nurse to make a connection.

Fast-Aid is a service hospitals have been asking for. Now it is here. You will be surprised at the low installation cost. Installations can be made for any size hospital and are made to tie in with existing signal systems if desired.

On the basis of your hospital experience, you can visualize the greater efficiency that will follow such a change in hospital routine. Write today for complete details of installation in accordance with the requirements of your own hospital.

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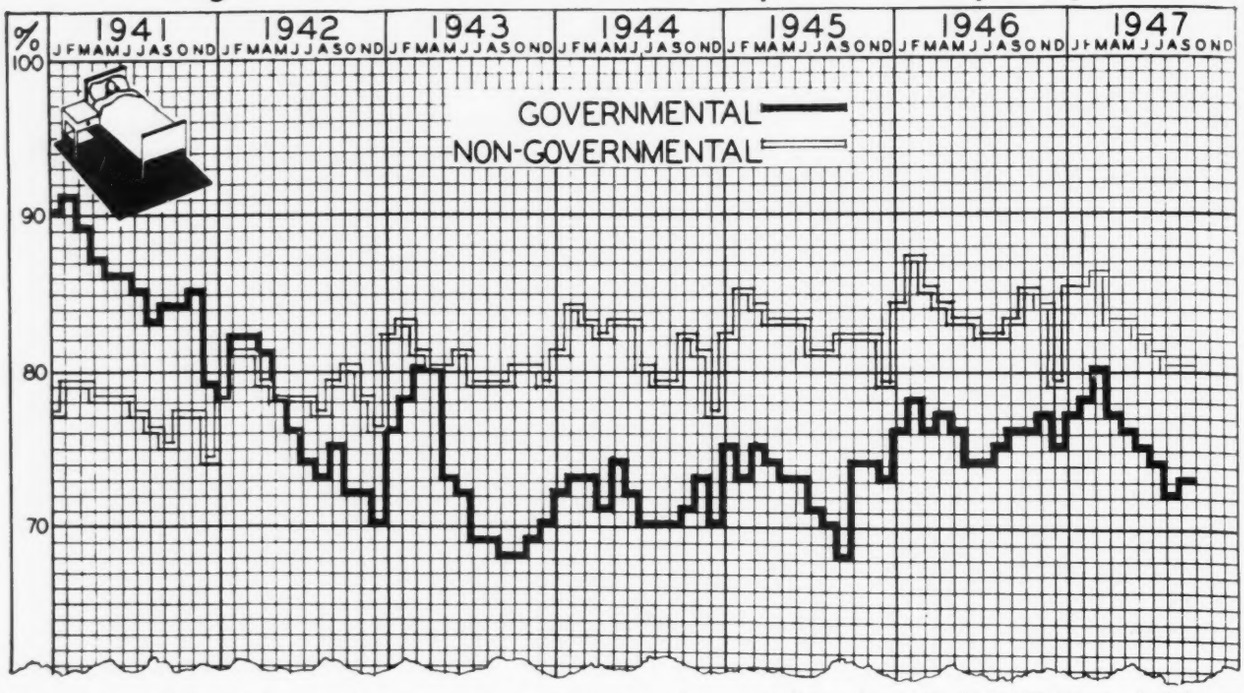
Slight Increase Shown in Hospital Occupancy



Nongovernmental hospitals reporting to the Occupancy Chart showed 80.2 per cent of beds filled, up a little from the previous month. Governmental hospitals, at 73 per cent, were also up some. Both groups were down from September 1946.

Apparently, projected new hospital construction is slowing down pending completion of survey and planning activities which will qualify specific projects for federal aid; construction for the current period, reported at $36,315,325, was less than the total for the same period a year ago, and the total to date for 1947, $314,177,410, is slightly under the figure for last year at this time. Of 71 new projects reported in October, 24 were new hospitals costing $12,000,000; 37 were additions costing $21,000,000; 10 were alterations, and two were nurses' homes.